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Supreme Court, U.S.
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In The
Supreme Court of The United States
October Term 1995

CHAIM SCHACHNER, individually, and as representative of all similarly situated persons,
Respondent,

v.

BLUE CROSS & BLUE SHIELD OF OHIO AND MUTUAL HEALTH SERVICES COMPANY,
Petitioners.

Petition For A Writ Of Certiorari To The United States Court of Appeals For The Sixth Circuit

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PETITION FOR WRIT OF CERTIORARI
With Appendix

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QUESTION PRESENTED FOR REVIEW

Must a district court, in interpreting de novo a health insurance agreement subject to ERISA, disregard evidence of the parties' intent unless it finds a patent ambiguity in the language contained on the face of the agreement?

PARTIES TO THE PROCEEDING

Petitioners are Blue Cross & Blue Shield Mutual of Ohio and Mutual Health Services Company. The parent of Mutual Health Services Company is Mutual Holding Company, a wholly owned subsidiary of Blue Cross & Blue Shield Mutual of Ohio. Blue Cross & Blue Shield Mutual of Ohio has no parent. However, Blue Cross & Blue Shield Mutual of Ohio has one nonwholly owned subsidiary, Medical Insurance Company of Ohio. Also, in March 1996, Blue Cross & Blue Shield Mutual of Ohio entered into an agreement with Columbia/HCA Healthcare Corporation, a publicly-owned company, the terms of which include the sale, upon closing, of one hundred percent of the capital stock of a subsidiary to be formed to which most of the assets of Blue Cross & Blue Shield Mutual of Ohio will be transferred after appropriate approvals have been received.

Respondent, Chaim Schachner, is an individual.

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IN THE SUPREME COURT OF
THE UNITED STATES

CHAIM SCHACHNER	)	
	)	
Respondent	)	
	)	
vs.	)	
	)	
BLUE CROSS & BLUE SHIELD MUTUAL OF OHIO AND MUTUAL HEALTH SERVICES COMPANY	)	Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit
	)	
Petitioners	)	

PETITION FOR WRIT OF CERTIORARI

Blue Cross & Blue Shield of Mutual Ohio and Mutual Health Services Company ("Blue Cross") respectfully ask that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit is reported at 77 F.3d 889 (6th Cir. 1996) and is reproduced in the Appendix ("App.") attached to this Petition at App. A. The opinions of the District Court for the Northern District of Ohio denying plaintiff's motion and amended motion for certification, denying plaintiff's motion for reconsideration, denying plaintiff's second amended motion for certification, granting defendants' motion to dismiss, and granting defendants' motion for summary judgment are unreported and are reproduced at Apps. B, C, D, E and F respectively.

STATEMENT OF JURISDICTION

The judgment of the Court of Appeals was entered on March 8, 1996. A timely petition for rehearing with suggestion for rehearing en banc was denied on April 15, 1996. App. H.

This Court has jurisdiction pursuant to 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

The statutes involved are the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001, et. seq.

and Section 301 of the Labor Management Relations Act of 1947, 29 U.S.C. 185 (LMRA). Pertinent text of provisions of bothstatutes are set out at Apps. I and J.

STATEMENT OF THE CASE

A. Overview and Summary

This petition involves a direct conflict among the circuits as to a threshold rule of contract interpretation to be applied by federal courts in their de novo review of pension plan agreements subject to ERISA in accordance with this Court's decision in Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 110-111 (1989).

In Firestone this Court stated that, in carrying out a de novo review, federal courts are to interpret ERISA regulated agreements under trust law "in light of all the circumstances and such other evidence of the intention of the settlor with respect to the trust as is not inadmissible." Firestone, 489 U.S. at 112, citing, Restatement (Second) of Trusts §4, Comment d (1959).

This case involves the de novo interpretation of an ERISA regulated employee health insurance agreement. The dispute concerns whether the parties intended a particular medical service to be included in a specific phrase set forth in the provisions of that agreement. An employee claimed that, although the medical service was not specifically listed, certain language in the plan could be interpreted as covering the service. Blue Cross presented

evidence that the language could not be so interpreted because its custom and practice was to specifically describe the particular service at issue in a separate paragraph when it was intended to be included as a covered service.

The District Court considered Blue Cross' evidence, and after finding that the employee presented no contrary evidence, granted summary judgment to Blue Cross. In reversing, the Court of Appeals held, as a matter of law, that Blue Cross's evidence of the parties' intent should not have been considered by the District Court because Blue Cross had not pointed to a "patent" ambiguity in the language on the face of the contract. App. A-7. The Court held that since Blue Cross did not demonstrate a patent defect or obscurity in the language used in the particular provision involved which was "apparent on the face of the contract", Blue Cross's dispositive "extrinsic evidence" of intent must be disregarded. Id.

The Court of Appeals for the First, Third, Seventh, Eighth and Ninth Circuits have held to the contrary in ERISA cases. Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 585-6 (1st Cir. 1993); Taylor v. Continental Group, 933 F.2d 1227, 1232-35 (3rd Cir. 1991), (adopting in ERISA cases the rule of contract interpretation set forth in Mellon Bank, N.A. v. Aetna Business Credit, 619 F.2d 1001, 1011-1014 (3rd Cir. 1980)); Miller v. Taylor Insulation Company, 39 F.3d 755, 760 (7th Cir. 1994); Landro v. Glendenning Motorways, Inc., 625 F.2d

1344, 1353 (8th Cir. 1980). Jensen v. Sipco, Inc., 38 F.3d 945, 950 (8th Cir. 1994); Bolton v. Construction Laborers' Pension Trust for Southern California, 56 F.3d 1055, 1059 n.2 (9th Cir. 1995).

These circuits have held that in ERISA cases federal courts must review any evidence submitted by the parties to determine whether there is any latent ambiguity in the interpretation or application of the language in the agreement - even if there is no patent ambiguity on the face of the agreement. If, after such review, there may be reasonable multiple interpretations or meanings of that language, these circuits require an ERISA court to use the evidence presented to resolve that latent ambiguity. The same rule has been applied by the Third, Seventh, Eighth & Ninth Circuits in LMRA cases. International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW v. Mack Trucks, Inc., 917 F.2d 107, 111-112 (3rd Cir. 1990), cert. denied, 499 U.S. 921 (1991); Randall v. Lodge No. 1076, Int'l. Ass'n. of Machinists and Aerospace Workers, AFL-CIO, 648 F.2d 462, 466 (7th Cir. 1981); John Morrell & Co. v. Local Union 304A of the United Food and Commercial Workers, AFL-CIO, 913 F.2d 544, 551 (8th Cir. 1990), cert. denied, 500 U.S. 905 (1991); Forrest Industries, Inc. v. Local Union

No. 3-436, Int'l. Woodworkers of America, AFL-CIO, 381 F.2d 144, 146 (9th Cir. 1967)[1]

This conflict is of great importance. Congress has unmistakably ordained that the enforcement of a federal common law of rights and obligations under ERISA regulated plans shall be uniform in character throughout the nation. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52-57 (1987); Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 156-7 (1985) Since the validity of a claim to benefits under any ERISA regulated plan is likely to turn on the interpretation of the terms of such rights and obligations (Firestone, supra, 489 U.S. at 113) the necessity for uniformity in the threshold rules of ERISA contract interpretation is of the highest importance in carrying out the intent of Congress.

Thus, the Petition should be granted. All of the traditional criteria for the exercise of this Court's certiorari jurisdiction are indisputably met here. (See Sup. Ct. Rule 10.1).

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[1] The similarity in treatment in ERISA and LMRA cases results from the fact that Congress consciously and deliberately modeled the pre-emptive provisions of ERISA after §301 of LMRA. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52-57 (1987)

B. The Proceedings In The District Court

Chaim Schachner ("Schachner") filed a class action complaint in August, 1990 seeking payment from Blue Cross for thirty-three separate charges for Schachner's participation in a program of Cardiac Rehabilitation Phase II ("Cardiac Rehab")[2]. While acknowledging that his Certificate of Insurance ("Certificate") did not include any reference to Cardiac Rehab, Schachner claimed that his participation in the Cardiac Rehab was a covered benefit entitling him to coverage because his Certificate contained language making "Treatment By Physical Means" a covered benefit.[3]

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[2] Cardiac Rehab is a group of different services packaged together by health care providers. It may include x-rays, laboratory work, stress testing, monitored counseling and educational or training programs to educate the patient about changes in his or her lifestyle. App. C-46 n.1.

[3] "Treatment by Physical Means" is listed in Schachner's Certificate as follows:

> The treatment given to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar

Blue Cross contended that Cardiac Rehab was not a covered benefit under the "Treatment By Physical Means" language because Blue Cross followed a custom and practice of including Cardiac Rehab as a separately identified benefit when negotiated by a group, and Schachner's group had neither negotiated for, nor purchased, the Cardiac Rehab benefit while other groups had done so. Groups that had negotiated for Cardiac Rehab had Certificates which did contain a covered benefit specifically identified as Cardiac Rehab that was included as a specific separate benefit in addition to "Treatment By Physical Means". Since Schachner's group did not bargain for any such coverage, Schachner could not offer an interpretation of its language of "Treatment by Physical Means" as if it did.

The District Court, in initially deciding Schachner's Motion for Class Certification and Amended Motion For Class Certification, declared the language "Treatment By Physical Means" to be ambiguous as well as "unintelligible". The Court stated, [b]ecause the clause is clearly ambiguous, parol evidence must come in to clarify

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modalities, physical agents, hyperbaric therapy, bio-mechanical and neurophysiological principles and devices. Joint Stipulation Of Facts, App. O at O-155.

what the parties to the contract intended by this language." App. B-39.

After the initial District Court judge was appointed to the Sixth Circuit, Schachner requested a reconsideration of the ruling. The finding of ambiguity was upheld and the case proceeded. Eventually, both parties filed motions for summary judgment.

In connection with the cross motions for summary judgment, both parties submitted a substantial amount of uncontested evidence and stipulations of fact which included the following:

- Schachner's Certificate does not mention Cardiac Rehab App. M-0143, ¶. 9-10.

- Blue Cross does issue Certificates which specifically include Cardiac Rehab Statement Of Uncontested Fact, App. N. at N-130.

- Blue Cross' denial of benefits was because Schachner's employer did not select a contract to provide additional benefits for Cardiac Rehab. App. 0-145, ¶. 19.

In denying Schachner's motion and granting Blue Cross' motion, the District Court found that Schachner had

failed to provide any evidence that either party intended Cardiac Rehab to be included in Schachner's Certificate.[4]

C. The Opinion Of The Court Of Appeals

The Court of Appeals reversed the District Court's grant of summary judgment and vacated the orders disposing of the class certification motions.

The Court of Appeals held that the District Court erred as a matter of law in considering the evidence and stipulations submitted by the parties since there was no "patent" ambiguity "on the face of the contract". App. A-7. Without such a "patent ambiguity", evidence of Blue Cross's custom and practice of providing a separate listing for Cardiac Rehab when it was intended by the parties to be a covered service must be disregarded. Id.

In reaching its conclusion, the Court of Appeals criticized and rejected its own prior opinion interpreting a

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[4] Schachner's evidence was to the effect that 1) he never considered whether his Certificate included Cardiac Rehab until after his claims were denied (Deposition of Chaim Schachner, App. M at M-128 to M-129); 2) the entity purchasing coverage from Blue Cross on Schachner's behalf never discussed Cardiac Rehab (App. O-142 to O-143, ¶ 5-8); and 3) the Program Supervisor for Schachner's Cardiac Rehab did not think Blue Cross provided coverage for Cardiac Rehab (Affidavit of Benjamin Meola, App. K at K-120, ¶¶ 14 and 15).

collective bargaining agreement case subject to the Labor Management Relations Act of 1947, 29 U.S.C. 185, (LMRA). International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW, v. Yard-Man, 716 F.2d 1476 (6th Cir. 1983), cert. denied, 465 U.S. 1007 (1984).

The Sixth Circuit had held in Yard-Man that "[t]he intended meaning of even the most explicit language can, of course, only be understood in light of the context which gave rise to its inclusion." Yard-Man, supra, at 1479. The cases cited by the panel in Yard-Man for this proposition were collective bargaining cases from the Seventh and Ninth Circuits. The first such case, Randall v. Lodge No. 1076, Int'l. Ass'n. of Machinists and Aerospace Workers, AFL-CIO, 648 F.2d 462, 466 (7th Cir. 1981), held that a collective bargaining agreement must be viewed "in the light of its language, its context, and any other indicia of the parties' intention". Id., citing, F. W. Woolworth Co. v. Miscellaneous Warehousemen's Union, 629 F.2d 1204, 1215 (7th Cir. 1980) The second such case, Forrest Industries, Inc. v. Local Union No. 3-436, Int'l. Woodworkers of America, AFL-CIO, 381 F.2d 144, 146 (9th Cir. 1967), noted:

> As Mr. Justice Brennan has observed, words in particular collective bargaining agreements are like words in a statute. The same word may have different meanings in different contexts and the language in each agreement should be construed

> with reference the particular practices, background and milieu which gave rise to its use.

Id., citing, United Steelworkers of America v. American Mfg. Co., 363 U.S. 564, 569 (1960).

Thus Yard-Man was part of a uniform common law rule in LMRA cases that required the consideration of extrinsic evidence of the parties' intent without any prior requirement of textual ambiguity on the face of the agreement.

The Court below, in rejecting the adoption of the Yard-Man rule in ERISA cases and overruling Yard-Man in LMRA cases, explicitly rejected a uniform federal common law rule by declaring:

> "Thus, in this circuit, before a district court can consider extrinsic evidence of the parties' intent, it must find an ambiguity on the face of the contract."

(App. A-8 to A-9) (emphasis added).

REASONS FOR GRANTING THE WRIT

This case more than satisfies virtually all traditional criteria for the exercise of the Court's certiorari jurisdiction. See Sup. Ct. R. 10.1. Where Congress and this Court have mandated uniformity, the Court of Appeals has created conflict and confusion not only in ERISA cases, but also in LMRA cases on a purely legal question of federal law. This Court in Firestone Tire & Rubber Co. v. Bruch, 489

U.S. 101, 110-111 (1989), established the principles for the interpretation of ERISA by federal courts using a de novo standard of review. The Court of Appeals' decision squarely conflicts with Firestone and with ERISA decisions in at least five other circuits, as well as with LMRA decisions in at least four of those same circuits. Moreover, the remaining circuits, as well as the Sixth Circuit itself, have issued a number of conflicting decisions on the same issue. The resolution of this issue by the Court is now ripe for review.

The issues presented are of manifest importance. The validity of any claim to benefits under any ERISA regulated plan is likely to turn on the threshold interpretation of the terms in the plan at issue. Id. at 113. Congress has provided that federal common law regulating the rights and obligations under ERISA shall be uniform throughout the nation. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52-57 (1987). Therefore, it is of the highest importance in carrying out the legislative purpose of ERISA that the threshold rules of contract interpretation utilized by all circuits be the same. Absent review by this Court, this will not be so.

A. The Conflicts With Other Circuits

The Courts of Appeal for the First, Third, Seventh, Eighth and Ninth Circuits have all held that if extrinsic

evidence of the intent of the parties is offered to a federal court in ERISA cases, it must be considered by the court in order to determine whether a latent ambiguity exists as to that intention; even if the language on the face of the contract appears unambiguous. Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 585-6 (1st Cir. 1995) (adopting as federal common law in ERISA cases a rule that extrinsic evidence is permitted to interpret the language of an agreement that both parties agree is plain and unambiguous); Taylor v. Continental Group Change in Control Severance Pay Plan, 933 F.2d 1227, 1232 (3d Cir. 1991) (adopting in ERISA cases the rule set forth in Mellon Bank N.A. v. Aetna Business Credit, 619 F.2d 1001, 1011 (3d Cir. 1980) rejecting the "four corners" approach in favor of "the role of the judge to consider the words of the contract, the alternative meaning suggested by counsel, and the nature of the objective evidence to be offered in support of that meaning"); Miller v. Taylor Insulation Company, 39 F.3d 755, 760 (7th Cir. 1994) (adopting as federal common law in ERISA cases a rule recognizing that ambiguities can be "latent" and may appear only after the context of an agreement is applied to the matter at hand); Landro v. Glendenning Motorways, Inc., 625 F.2d 1344, 1353 (8th Cir. 1980) (adopting in ERISA cases the Restatement of Contracts rule that any determination of meaning or ambiguity should only be made in the light of relevant evidence of the situation and relations of the parties, the

subject matter of the transaction, preliminary negotiations and statements made, trade usage and the parties' course of dealing) Bolton v. Construction Laborers' Pension Trust for Southern California, 56 F.3d 1055, 1059 n.2 (9th Cir. 1995) (establishing the rule in ERISA cases that a latent or extrinsic ambiguity exists when, although the agreement itself is perfectly understandable, the context of the agreement would raise questions as to its proper interpretation.)

In Jensen v. Sipco, Inc., 38 F.3d 945, 950 (8th Cir. 1994), the Eighth Circuit referred to this Court's opinion in Firestone, supra, at 112 and held as follows:

> When interpreting ERISA plan documents, the Supreme Court has referred us to, and explicated, the law of trusts:
>
> > The terms of trusts created by written instruments are "determined by the provisions of the instrument as interpreted in light of all the circumstances and such other evidence of the intention of the settlor with respect to the trust as is not inadmissible."
>
> *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112, 109 S.Ct. 948, 955, 103 L.Ed.2d 80 (1989), quoting Restatement (Second) of Trusts § 4 cmt. d (1959). The question of what "other evidence" is admissible turns on the relative ambiguity of the plan provision being construed:

> That intent [of the settlor] is first sought by careful examination of the trust clause in question, giving the words in that clause their ordinary meanings. If the construction question cannot be resolved by reference to the clause alone, the court will examine the entire trust instrument to determine the creator's intent and purposes.... The third step becomes necessary when the intent or meaning of the settlor...cannot be determined by reference to the provisions of the trust instrument itself. Extrinsic evidence will be admitted by the court to assist it in determining the meaning and effect of the particular clause. (Emphasis added)
>
> George C. Bogert, The Law of Trusts & Trustees § 182 (rev. 2d ed. 1979 & Supp 1993) (footnotes omitted) (Citation omitted)

Jensen, 38 F.3d at 950

The Third, Seventh, Eighth and Ninth Circuits have also adopted the same rule in interpreting employer-employee agreements in LMRA cases. International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW, v. Mack Trucks, Inc., 917 F.2d 107, 111 (3rd Cir. 1990), cert. denied, 499 U.S. 921 (1991); Randall v. Lodge No. 1076, Int'l. Assoc. of Machinists and Aerospace Workers, AFL-CIO, 648 F.2d 462, 466 (7th Cir. 1981); John Morrell & Co. v. Local Union 304A, of the

United Food and Commercial Workers, AFL-CIO, 913 F.2d 544, 551 (8th Cir. 1990), cert. denied, 500 U.S. 905 (1991) Forrest Industries, Inc. v. Local Union No. 3-436 Int'l. Woodworkers of America, AFL-CIO, 381 F.2d 144, 146 (9th Cir. 1967). As stated by the Third Circuit in Int'l. Union, UAW:

> Ambiguity is:
> Intellectual uncertainty; ... the condition of admitting of two or more meanings, of being understood in more than one way, or referring to two or more things at the same time..."
>
> In making the ambiguity determination, a court must consider the words of the agreement, alternative meanings suggested by counsel, and extrinsic evidence offered in support of those meanings.

917 F.2d at 111 (citations omitted).

Consequently, when the Court below explicitly refused to follow its own prior opinion in the Yard-Man case, and held that "In this Circuit, before a district court can consider extrinsic evidence of the parties' intent it must find an ambiguity on the face of the contract", (App. A-8 to A-9) a specific conflict was created by the Court below with these circuits in LMRA cases as well as ERISA cases.

The Second, Fifth, Tenth and Eleventh Circuits have adopted as rules of contract interpretation inconsistent rules obtained from a wide variety of sources.

For example, the Second Circuit held in Burger King Corp. v. Horn & Hardart Co., 893 F.2d 525 (2d Cir. 1990), that "[c]ontract language is ambiguous if it is a reasonably susceptible of more than one interpretation, and a court makes this determination by reference to the contract alone". Id. at 527. However, as early as 1964, in referring to the admissibility of extrinsic evidence, the Second Circuit held that "The better rule is that such evidence is always admissible where relevant to the interpretation of a contract..." Asheville Mica Company v. Commodity Credit Corporation, 335 F.2d 768, 770 (2nd Cir. 1964)

The Eleventh Circuit has similarly held both ways. In Stewart v. KHD Deutz of America Corporation, 980 F.2d 698, 702 (11th Cir. 1993), the Eleventh Circuit held that in LMRA cases "any ambiguities must be created by the language of the contract itself." Id. However, as early as 1983, the Eleventh Circuit had quoted with approval the rule set forth in the Restatement (Second) of Contracts which has no such patent ambiguity requirement.[5]

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[5] The Restatement rule states as follows:

> §212. Interpretation of Integrated Agreement
> (1) The interpretation of an integrated agreement is directed to the meaning of the terms of the writing or writings in the light of the circumstances, in accordance with

Cathbake Investment Company, Inc. v. Fisk Electric Company, Inc., 700 F.2d 654, 656 n.1 (11th Cir. 1983)

Additionally, the same Restatement rule was quoted with approval by the Fourth Circuit in a case interpreting a federal immunity agreement United States v. Smith, 976 F.2d 861, 864 (4th Cir. 1992); and by the Fifth Circuit in a diversity case, Haeberle v. Texas Int'l. Airlines, 738 F.2d 1434, 1439 (5th Cir. 1984).[6]

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the rules stated in this Chapter.

b. *Plain meaning and extrinsic evidence.* It is sometimes said that extrinsic evidence cannot change the plain meaning of a writing, but meaning can almost never be plain except in a context. Accordingly, the rule stated in Subsection (1) is not limited to cases where it is determined that the language used is ambiguous. Any determination of meaning or ambiguity should only be made in the light of the relevant evidence of the situation and relations of the parties, the subject matter of the transaction, preliminary negotiations and statements made therein, usages of trade, and the course of dealing between the parties. Restatement (Second) of Contracts, §212 (1979) (emphasis added).

[6] However, the Fifth Circuit, in United Paperworkers Int'l. Union, AFL-CIO v. Champion International Corp., 908 F.2d 1252 (5th Cir. 1990) appears to allow consideration of extrinsic evidence in LMRA and ERISA

A similar rule found in 3 Corbin on Contracts, ¶ 542, and ¶ 579 (1960) was quoted with approval by the Second Circuit in Asheville Mica Company v. Commodity Credit Corporation, 335 F.2d 768, 770 (2nd Cir. 1964) and by the Fifth Circuit in Pennzoil Co. v. Federal Energy Regulatory Comm'n., 645 F.2d 360, 388 (5th Cir. 1981), cert. denied, 454 U.S. 1142 (1991)

Furthermore, the rule of interpretation adopted by the Uniform Commercial Code has been utilized by at least one circuit as an additional source of federal common law. O'Neill v. U.S., 50 F.3d 677, 684 (9th Cir. 1995), cert. denied, 116 S.Ct. 672 (1995). In O'Neill, the Ninth Circuit cited to the Official Comment to U.C.C. Section 2-202 as follows:

> As the Official Comment states, "[t]his section definitely rejects...[t]he requirement that a condition precedent to the admissibility of the type of evidence specified in paragraph (a) is an original determination by the court that the language used is ambiguous." U.C.C. § 2-202, Comment § 1(c). Consistently with this interpretation, this court has observed that "[t]he Code lets in evidence of prior dealings, usage, and performance under 2-202(a) even if the contract terms are clear."

(50 F.3d at 684) (emphasis in original).

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cases only if the court first determines that the agreement on its face is ambiguous. Id. at 1257.

This U.C.C. rule has also been specifically adopted by the Tenth Circuit. Amoco Production Co. v. Western Slope Gas Co., 754 F.2d 303, 308-10 (10th Cir. 1985). In Amoco Production, the Tenth Circuit stated:

> Under the UCC, the lack of facial ambiguity in the contract language is basically irrelevant to whether extrinsic evidence ought to be considered by the court as an initial matter. A judge first must consider the circumstances and purposes surrounding the making of the writing before he or she can determine whether it is in fact ambiguous. "[I]t is proper to consider the contract's commercial setting even though the contract is not facially ambiguous."

(754 F.2d at 308) (citation omitted) (footnote omitted).

However, in 1991 the Tenth Circuit contradicted itself by declaring that extrinsic evidence is reviewed only "when [an] ambiguity exists on the face of a contract". Carland v. Metropolitan Life Ins. Co., 935 F. 2d 1114, 1120 (10th Cir. 1991), cert. denied, 502 U.S. 1020 (1991).

Thus it is evident that the question of federal law decided by the Court of Appeals below has been the subject of numerous differing and conflicting interpretations by most, if not all, of the circuits in a variety of circumstances over a long period of time. The confusion generated by this conflict is now ripe for resolution by this Court.

B. The Conflict With The Sixth Circuit's Own Prior Opinion

The Court of Appeals' opinion also overlooked a prior ERISA opinion of its own that is in direct conflict with its holding. Richards v. General Motors Corp., 991 F.2d 1227, 1233 (6th Cir. 1993). In Richards, the Sixth Circuit had found that the parol evidence rule set forth in the Restatement of Agency was applicable in ERISA cases. 961 F.2d at 1233. Richards cited the Restatement (Second) of Agency §48 ¶b (1983) as controlling the issue of contract interpretation in ERISA cases, and held as follows:

> "Under the parol evidence rule, extrinsic evidence for the purpose of modifying or adding to the terms of the agreement would be inadmissible. However, extrinsic evidence may be used even in conjunction with an integrated contract to illuminate the circumstances under which the agreement was consummated."

Id. (emphasis added).

Richards illustrates the important distinction in the treatment by extrinsic evidence that was recognized by other circuits in ERISA cases but overlooked by the Court of Appeals below: extrinsic evidence is properly excluded only if that evidence attempts to modify or add to the text of the agreement. Id. However, when the extrinsic evidence proffered does not attempt to add to or modify the text, but

is only offered to interpret or explain the text, such evidence is not excluded since there is every reason to include it, and no reason to exclude it. Id.

There is no dispute here that the evidence offered by Blue Cross here was only interpretative, and was not offered for the purpose of changing the language defining the term "Treatment by Physical Means" in Schachner's Certificate.[7]

Thus it was entirely proper under Richards for the District Court to have considered this evidence in order to interpret the agreement and "illuminate the circumstances under which the agreement was consummated". Id.

C. Resolution Of The Conflict Here Is Of The Highest Importance In Carrying Out The Legislative Purpose of ERISA

The civil enforcement provisions of ERISA are intended to be the exclusive method for ERISA plan participants and beneficiaries to assert improper processing of a claim for benefits. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52-57 (1987). The legislative history of ERISA shows that the preemptive provisions of ERISA were

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[7]The Court of Appeals below recognized this, when, in its order of remand, it directed the District Court to take evidence as to whether Schachner's Cardiac Rehab sessions "fit within" the definition of "Treatment by Physical Means". App. A-14.

modeled after Sec. 301 of the Labor-Management Relations Act of 1947, 29 U.S.C. 185, (LMRA) in order to achieve uniformity of decision throughout the Nation. Id. That uniformity cannot be achieved without the creation of a body of federal common law that is uniform. See Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 156-157 (1985); Shaw v. Delta Airlines, Inc., 463 U.S. 85, 99 (1983).

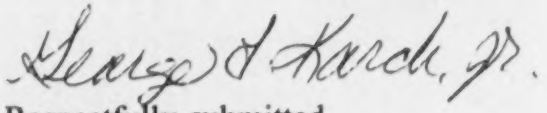
This Court has stated that the validity of a claim to benefits under an ERISA regulated plan is likely to turn on the interpretation of the terms in the plan at issue. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989) Thus, without a uniform federal common law rule of interpretation, the intent of Congress that rights and obligations under ERISA be the same throughout the Nation will be compromised at the threshold of every ERISA case.

It is therefore evident that the conflicts among the circuits as the proper rule to be adopted as federal common law in interpreting ERISA regulated agreements assumes an importance and significance of the highest order.

CONCLUSION

For the reasons set forth above, the Court's standards set forth in Sup. Ct. Rule 10.1 for granting

certiorari are more than satisfied here. The petition should be granted.



Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

OPINION

RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 24

No. 94-4217

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

CHAIM SCHACHNER, individually
and as representative of all
similarly situated persons,
Plaintiff-Appellant,

v.

BLUE CROSS AND BLUE SHIELD
OF OHIO AND MUTUAL HEALTH
SERVICES COMPANY,
Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of Ohio

Decided and Filed March 8, 1996

Before: BROWN, WELLFORD, and MILBURN, Circuit Judges.

BAILEY BROWN, Circuit Judge. In this Employee Retirement Income Security Act (ERISA) case,[1] Chaim Schachner sued Blue Cross and Blue Shield of Ohio ("BCBSO") after it refused to pay for cardiac rehabilitation therapy ("cardiac rehab") he received after undergoing a coronary surgical procedure called angioplasty. Schachner contends that the costs of cardiac rehab are covered under the plain language of the insurance certificate BCBSO issued to him. BCBSO counters that the language of the certificate is ambiguous, and that extrinsic evidence proves the parties did not intend to cover cardiac rehab. The district court agreed with BCBSO and granted it summary judgment. Schachner appeals.

Schachner also appeals from the district court's several orders denying his attempts to establish himself as the representative of a class of several similarly situated BCBSO insureds. Additionally, Schachner appeals from the court's dismissal of his various state law claims as pre-empted by ERISA.

For the reasons set forth below, we REVERSE the court's grant of summary judgment on the ERISA claims,

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[1]ERISA controls this case because the health insurance plan under which the plaintiff claims benefits is a "welfare benefit plan" as defined by 29 U.S.C. § 1002(1) (1988).

and VACATE the court's orders disposing of Schachner's attempts to have a class certified. We AFFIRM the district court's dismissal of Schachner's *individual* state law claims, but VACATE the dismissal of state law claims which could be maintained on behalf of potential class members whose insurance certificates are not controlled by ERISA. We REMAND this case to the district court for further proceedings consistent with this opinion.

I. FACTS

Schachner is a partner in and an employee of the Dallas Shoe Warehouse Co. ("the company"), a partnership specializing in retail shoe sales in Cleveland, Ohio. The company is a member of a group of Cleveland-area businesses called the Council of Small Enterprises ("COSE").[2] The company offered its employees health insurance plans which COSE had negotiated with BCBSO.

In May of 1989, Schachner underwent a coronary surgical procedure called angioplasty. Afterward, Schachner's physician prescribed for him a standard cardiac rehab program. Schachner participated in thirty-three treatment sessions over a five-month period. His doctor

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[2]It appears from the parties' briefs that COSE is an organization of small businesses existing to advance its members' common interests.

described the sessions as "consist[ing] of supervised exercise training to strengthen the muscles of the heart and the function of the circulatory system, surveillance of risk factors, appropriate counselling, and monitoring of progressive exercise to return Mr. Schachner to his pre-symptomatic level of function." The nurse who supervised the treatments said that the "sessions consisted of supervised training and exercise to strengthen the cardiovascular system by improving the function of the circulatory system."

BCBSO paid Schachner's claims for the angioplasty procedure, but denied his claims for cardiac rehab on the ground that cardiac rehab is not a covered service under his insurance certificate ("the certificate"). Schachner subsequently filed this suit, asserting claims under ERISA[3] and on state law grounds, on his own behalf and as a representative of a putative class of BCBSO insureds who have been denied coverage for cardiac rehab under similar insurance certificates.

Schachner's certificate includes, in a section headed "Health Care Benefits," a subheading called "Therapy

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[3]29 U.S.C. § 1132(e)(1) (Supp. V 1993) gives district courts jurisdiction over suits brought by ERISA plan beneficiaries for recovery of benefits allegedly due them.

Services." According to the certificate, "Therapy Services" includes radiation therapy, chemotherapy, dialysis treatments, **treatment by physical means**, respiratory and pulmonary therapy, and inpatient speech and occupational therapy. The paragraph addressing treatment by physical means states:

> **Treatment by Physical Means** - The treatment given to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical and neurophysiological principles and devices.

While the certificate specifically lists several "Exclusions," cardiac rehab is not among them.

Schachner contends that his cardiac rehab sessions fit squarely within the definition of Treatment by Physical Means. He relied on the affidavit of his physician, in which the doctor states:

> I have found cardiac rehabilitation services, such as those prescribed by me, to be an

> effective method of restoring function to the heart and circulatory system, combating heart disease, preventing future incidents of acute coronary distress, important adjunction therapy to help cardiac patients resume normal function as promptly as possible, and an effective method of improving of cardiac risk factors to help retard disease progression.

BCBSO, however, claims that it must pay for cardiac rehab only when it is separately listed as a covered service in the insurance certificate. It submitted to the district court copies of insurance certificates with separate listings for cardiac rehab.

II. ANALYSIS

A. The contract language at issue is not ambiguous.

1. The appropriate law to be applied

We review the district court's grant of summary judgment and denial of partial summary judgment *de novo,* applying the same test as the district court. *E.g., Pierce v. Commonwealth Life Ins. Co.*, 40 F.3d 796, 800 (6th Cir. 1994). Summary judgment is proper "if the pleadings,

depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c).

We can resolve most of this appeal by determining whether the district court erred in concluding that the meaning of the term "Treatment by Physical Means" is ambiguous. We review a district court's conclusions regarding ambiguity in contract language *de novo*. *Wulf v. Quantum Chem. Corp.*, 26 F.3d 1368, 1376 (6th Cir.) (citing *Boyer v. Douglas Components Corp.*, 986 F.2d 999, 1003 (6th Cir. 1993)), *cert. denied*, 115 S. Ct. 667 (1994). Contract language is ambiguous if it is subject to two reasonable interpretations. *Id.* (citing *Smith v. ABS Indus.*, 890 F.2d 841, 846-47 n.1 (6th Cir. 1989)). *If* a court determines that a contract provision is ambiguous, *then* it "may use traditional methods of contract interpretation to resolve the ambiguity, including drawing inferences and presumptions and introducing extrinsic evidence." *Boyer*, 986 F.2d at 1005.

Courts may not, however, use extrinsic evidence to create an ambiguity. Rather, the ambiguity must be patent; that is, apparent on the face of the contract. In *Local 783, Allied Industrial Workers v. General Electric Co.*, 471 F.2d

751 (6th Cir.), *cert. denied*, 414 U.S. 822 (1973), we wrote that "[o]nly when the court has determined that the contract is ambiguous is a construction of the clause necessary. After a finding of ambiguity has been made, '[extrinsic evidence] is admissible to aid in its interpretation.'" *Id.* at 757 (quoting *Tennessee Consol. Coal Co. v. United Mine Workers*, 416 F.2d 1192, 1198 (6th Cir. 1969), *cert. denied*, 397 U.S. 964 (1970)). Some have argued, based primarily on our opinion in *International Union, United Automobile Workers v. Yard-Man*, 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007 (1984),[4] that we have broadened our rule on the consideration of parol evidence since our opinion in *General Electric*. *See Local 836, United Automobile Workers v. Echlin, Inc.*, 670 F. Supp. 697, 701 n.1 (E.D. Mich. 1986) ("The *Yard-Man* line has substantially eroded the *General Electric* principle, at least in the retiree benefits context."). In the 1986 case of *Serrano v. Jones & Laughlin Steel Co.*, 790 F.2d 1279 (6th Cir. 1986), however, we stated that "*Yard-Man* did not change the rule stated by this court in [*General Electric*]." *Id.* at 1288. Thus, in this circuit, before a district court can consider

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[4]In Yard-Man, we stated, among other things, that "even the most explicit language can, of course, only be understood in light of the context which gave rise to its inclusion." 716 F.2d at 1479.

extrinsic evidence of the parties' intent, it must find an ambiguity on the face of the contract.

2. Applying the appropriate law to this case

The district court ultimately granted summary judgment to BCBSO after concluding (1) that the meaning of the phrase "Treatment by Physical Means" is ambiguous, and (2) that evidence presented by BCBSO eliminated any genuine issue of material fact as to whether the parties intended that phrase to include cardiac rehab.

In 1991, Schachner filed a motion to certify a class of BCBSO insureds who had been denied coverage for cardiac rehab despite the fact that their insurance certificates stated that "Treatment by Physical Means" was a covered service. The district court (Batchelder, J.)[5] denied the motion, stating: "This Court cannot say that in this case the common questions of law and fact predominate over questions affecting only individual members." Explaining itself, the court wrote:

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[5]This case was filed before then-District Judge Batchelder, before her appointment to the Sixth Circuit Court of Appeals. After that appointment, the case was transferred to Judge Matia.

> The language in plaintiff's certificate describing "Treatment by Physical Means" includes the terms "physical treatments" and physical agents," but does not define these phrases. This language is not only ambiguous; it is unintelligible. Because the clause is clearly ambiguous, parol evidence must come in to clarify what the parties to the contract intended by this language.

The court determined that the parol evidence could evince differing intentions from one insured's negotiation with BCBSO to the next, and that therefore the issues would not be common to the class.

Nearly three years later, in 1994, in granting BCBSO's motion for summary judgment, the court (Matia, J.) stated: "The law of the case is that the 'Treatment by Physical Means' language *is* ambiguous!" The court then relied on extrinsic evidence submitted by BCBSO, in the form of BCBSO insurance certificates which specifically include cardiac rehab as a covered service, to "hold that plaintiff's Cardiac Rehab is not a Covered Service requiring that Blue Cross reimburse plaintiff under the insurance contract."

We hold that the district court erred in granting summary judgment. In its 1991 memorandum opinion, the court determined, for the purpose of denying a motion to certify a class, that "Treatment by Physical Means" is an ambiguous phrase. There is no indication in the record before us that, at that point in the litigation, the parties had either briefed or argued the ambiguity issue. Whether or not the prior judge erred in making that *sua sponte* determination in the 1991 memorandum opinion, the later judge erred in relying on the determination as "the law of the case" in 1994. The law of the case doctrine is not so rigid that it requires a judge to follow a prior ruling, which is not a final order and has not been the subject of an appeal, as if the issue is *res judicata*. *Cale v. Johnson*, 861 F.2d 943, 947 (6th Cir. 1988) ("Law of the case directs a court's discretion, it does not limit the tribunal's power."); *Amen v. City of Dearborn*, 718 F.2d 789, 793-94 (6th Cir. 1983) ("[T]he doctrine is not so rigid as the rule of *res judicata*."), *cert. denied*, 465 U.S. 1101 (1984). This would be true when the prior ruling is only part of a decision denying a preliminary motion.

Thus, the later judge should not have granted summary judgment based on BCBSO's extrinsic evidence without making an informed determination that "Treatment by Physical Means" is, in fact, ambiguous. As indicated above, a court cannot make such a determination unless the

parties present it with two plausible interpretations of the contract language.

Schachner contends that there is no ambiguity in the contract provision at issue, because it is clearly defined in the certificate. The certificate defines "Treatment by Physical Means" as "the treatment given to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part." It goes on to list the following examples of treatments by physical means, stating: "Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical and neurophysiological principles and devices." The language of that sentence--specifically, "such services include"--indicates that this list is not exclusive, but rather is intended to illustrate some of the services that fall within the definition of "Treatment by Physical Means." Indeed, if the parties intended the list to be exclusive, there would have been no need to define the phrase at all. Thus, Schachner asserts that we must interpret the phrase "Treatment by Physical Means" as the certificate defines it, and that the parties intended that phrase to include any treatment that falls within the definition.

BCBSO counters with extrinsic evidence, *i.e.*, other insurance certificates which specifically include cardiac

rehab as a covered service. BCBSO argues that it considers cardiac rehab to be a covered service only if it is specifically included in the insurance certificate, and therefore the parties could not have intended for cardiac rehab to be covered under the heading "Treatment by Physical Means." As we have explained, however, BCBSO must make its showing of ambiguity *without* resorting to extrinsic evidence. If the contract provision is not ambiguous on its face, the court must enforce it as written.

In *Serrano*, we rejected the plaintiff's attempt to rely on extrinsic evidence to create an ambiguity in an agreement which we found to be patently unambiguous. 790 F.2d at 1288-89. We will not allow BCBSO to attempt the same maneuver here. Only Schachner has drawn a plausible interpretation of "Treatment by Physical Means" from the text of the certificate. Therefore, we hold that the meaning of that phrase is unambiguous, and that it should be interpreted as it is defined in the certificate. The parties intended to cover "treatment[s] given to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part."[6]

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[6]The parties devote considerable portions of their briefs to discussing the procedure this court should follow in construing

Our holding on this issue does not, however, end this case. There may be an issue of fact remaining as to whether Schachner's cardiac rehab sessions fit within the unambiguous definition of "Treatment by Physical Means." Schachner maintains, with evidence to support him (in the form of affidavits from his doctor and rehab supervisor), that his sessions fit squarely within the definition. The evidence Schachner cites is persuasive. Schachner's doctor states in an affidavit that cardiac rehab restores function to the heart and circulatory system, combats heart disease, helps prevent future coronary problems, helps cardiac patients resume normal function, and retards disease progression. BCBSO may wish to present evidence indicating that the sessions Schachner underwent do not fit

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ambiguous contract provisions. Schachner invites us to outline exactly which common law rules of construction we will follow and invites us to specifically adopt the rule of contra proferentum, requiring courts to construe ambiguous contract clauses against the drafting party, in ERISA health insurance cases. BCBSO argues that *contra proferentum* is not applicable to this case because, it claims, the terms of Schachner's certificate were negotiated by two highly sophisticated parties, *i.e.*, BCBSO and the COSE insurance committee. Schachner counters that there actually were no negotiations over specific terms, but rather that the negotiations focused on different premiums and "benefit bundles."

The arguments the parties advance are interesting and well-supported. Since we hold that the phrase at issue is not ambiguous, however, we need not consider them.

within the certificate's definition of "Treatment by Physical Means," and we will remand the case for further proceedings on this issue.

That the insured and the insurer may disagree over whether a particular treatment or procedure falls within an insurance certificate's scope of coverage does not necessarily make the language of the certificate ambiguous. It is often necessary for health insurers to use broad language in drafting insurance contracts. It would be impracticable, if not impossible, to include an exhaustive list of the treatments and procedures covered by a general health insurance contract. The language is ambiguous only if, on its face, it admits of two different interpretations.

B. The district court erred in denying Schachner's attempts to certify a class.

We review a district court's grant or denial of class certification for an abuse of discretion. *Kentucky Educators Pub. Affairs Council v. Kentucky Registry of Election Fin.*, 677 F.2d 1125, 1135 (6th Cir. 1982). "An abuse of discretion exists when the district court applies the wrong legal standard, misapplies the correct legal standard, or relies on clearly erroneous findings of fact." *First Technology Safety Sys. v. Depinet*, 11 F.3d 641, 647 (6th Cir. 1993).

Through the course of the proceedings below, the district court issued three memorandum opinions in which it denied various attempts by Schachner--through motions to certify and motions to amend--to allege a class narrow enough in scope to obtain the court's certification under Federal Rule of Civil Procedure 23. After reviewing each of the district court's opinions, it is clear that, in every instance, its refusal to certify a class proposed by Schachner stemmed from its 1991 conclusion that "Treatment by Physical Means" is ambiguous. Essentially, the court reasoned that, since the clause at issue was ambiguous, it would have to consider extrinsic evidence of negotiations between BCBSO and its individual insureds or groups of insureds to construe the meaning of the clause. The court reasoned that the individual negotiations probably proceeded differently, and therefore that individual insureds were likely to have different intentions regarding the meaning of "Treatment by Physical Means." The court then concluded that individual questions of law and fact would predominate over common ones thus the requirements of Rule 23 would be unsatisfied.

If one assumes that "Treatment by Physical Means" is ambiguous, then the district court's analysis is valid. Our holding that the clause is not ambiguous, however, compels us to vacate the court's orders denying class certification. The district court abused its discretion in

basing its denials of class certification on an incorrect legal conclusion, *i.e.*, that the language is ambiguous. In view of our holding, the district court, on remand, should allow Schachner to attempt to certify a class, and should re-examine his proposed class under Rule 23.

C. Schachner's state law claims are pre-empted by ERISA.

Schachner brought this action under both ERISA and state law. The district court dismissed the following claims brought under state law, finding that ERISA pre-empted the state laws under which the claims were made:[7] (1) a claim for breach of contract, (2) a tort claim for the alleged bad faith refusal to pay an insurance claim, and (3)

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[7]ERISA's preemption clause provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a) (1988). For purposes of this section, "[t]he term 'State law' includes all laws, decisions, rules, regulations, or other state action having the effect of law, of any state." 29 U.S.C. § 1144(c)(1) (1988).

a negligence claim based on an alleged violation of Ohio's prompt payment statute.

Schachner presents two arguments on appeal. First, he contends the district court erred in dismissing the state law claims, since it is possible that some class members (if a suitable class is ever certified) could have insurance policies not governed by ERISA. Schachner points out that if his class includes a member or members who attained their BCBSO insurance in a manner other than through an employee welfare benefit plan, their state law claims would not be pre-empted by ERISA. In view of our holding, *supra*, that the certificate is not ambiguous, it remains theoretically possible for Schachner to achieve certification of a class that includes members who were denied coverage under insurance policies not regulated by ERISA.

After reviewing the district court's opinions and orders addressing the state law claims, we find that the court initially denied BCBSO's motions to dismiss the claims because of the possibility that some class members could assert state law claims, stating: "Defendant's motion is denied, but without prejudice to its being renewed once plaintiff has [reattempted class certification]." Two years later, after two additional failed attempts to persuade the district court to certify a class, the court dismissed the state law claims. On remand, Schachner will again have an

opportunity to propose a certifiable class. We therefore vacate the district court's order dismissing the state law claims, pending its resolution of Schachner's next attempt at certification.[8]

Second, in support of his state law bad faith claim, Schachner argues that, even assuming he proceeds individually, the district court erred in dismissing that claim. Schachner asserts that the ERISA "savings clause"

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[8]We seriously doubt, however, that Schachner will be able to persuade the district court to certify a class which includes both state law and ERISA claimants. Schachner, who can assert only federal ERISA claims, would be unable to adequately represent a class which includes state law claimants, because his claims would not be typical of theirs, as Federal Rule of Civil Procedure 23(a)(3) requires. Moreover, while Schachner could seek out a state law claimant to name as an additional class representative, it is unlikely that such a plaintiff would be able to invoke the jurisdiction of the district court; for, being without any federal law claims for relief, the putative representative would have to satisfy the citizenship and amount in controversy requirements of federal diversity jurisdiction. See, Snyder v. Harris, 394 U.S. 332, 340 (1969) (stating that each named plaintiff representing a class must satisfy federal court jurisdictional requirements); *see also National Center for Immigrants' Rights v. Immigration & Naturalization Serv.*, 791 F.2d 1351, 1353 (9th Cir. 1986) ("The class certified must be limited to individuals who meet the requirements of the relevant jurisdictional statutes."), *vacated on other grounds*, 481 U.S. 1009 (1987).

saves the bad faith claim from pre-emption. ERISA's savings clause states, in pertinent part, that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(a) (1988). Schachner points out that Ohio common law places upon insurers a "duty to act in good faith in the handling and payment of the claims of its insured." *Hoskins v. Aetna Life Ins. Co.*, 452 N.E.2d 1315, 1316 (Ohio 1983). Schachner asserts that this duty is a law of Ohio which regulates insurance, and thus is saved from ERISA pre-emption.

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), the Supreme Court addressed an identical claim regarding a provision of Mississippi common law strikingly similar to the Ohio law at issue in this case. In considering whether a particular law regulates insurance, the Supreme Court first "took what guidance [is] available from a 'common-sense view' of the language of the savings clause itself." *Id.* at 48. The Court stated that "to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Id.* at 50. Next, the Court considered the criteria used to determine whether a practice falls within

"the business of insurance" for purposes of the McCarren-Ferguson Act.[9] Specifically, the Court addressed:

> *[F]irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and, *third*, whether the practice is limited to entities within the insurance industry."

Id. at 48-49 (alteration in original) (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

After due consideration, the Supreme Court decided that ERISA pre-empted Mississippi's common law tradition of allowing a tort claim for punitive damages arising out of a bad faith breach of contract. *Id.* at 57. Schachner argues, however, that the instant case is distinguishable from *Dedeaux* because, he claims, Ohio allows tort actions for bad faith breaches of contract only against insurers, and not against contracting parties outside the insurance

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[9]The McCarren-Ferguson Act provides, in part, that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a) (1994).

industry. Thus, Schachner maintains that the Ohio law is "specifically directed" toward the insurance industry, and is therefore saved from pre-emption. At first blush, this argument seems appealing. The Supreme Court stated in *Dedeaux*, however, that

> [e]ven though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.

Id. at 50.

After reviewing the case law, we conclude that, while in Ohio tort actions are generally unavailable in breach of contract cases no matter how willful or malicious the breach, *Ketcham v. Miller*, 136 N.E. 145, 146 (Ohio 1922), there is an exception to this rule. "[O]nly in those contract situations where a special or fiduciary relationship exists between the parties and imposes a duty of good faith will the breach of [contract] result in a tortious cause of action." *Empire-Detroit Steel Div. Cyclops Corp. v. Pennsylvania Elec. Coil, Inc.*, No. CA-2903, 1992 WL 173313, at 3 (Ohio Ct. App. June 29, 1992). Hence, the

availability of a tort claim against an insurer for a bad faith refusal to pay a claim does not exist independent of traditional, generally-applicable common law; rather, it exists simply because of the Ohio courts' determination that the relationship between insurer and insured gives rise to a fiduciary duty, and that a breach of that duty is tortious.

Thus, we conclude that the differences between the Ohio law in this case and the Mississippi law in *Dedeaux* are differences of degree only. As far as ERISA pre-emption is concerned, there is no difference at all. The Ohio common law right to a tort action for an insurer's bad faith breach of an obligation to pay a claim is pre-empted by ERISA.

III. CONCLUSION

We REVERSE the district court's grant of summary judgment on the ERISA claims, and VACATE the court's orders disposing of Schachner's attempts to have a class certified. We AFFIRM the district court's dismissal of Schachner's individual state law claims, but VACATE the dismissal of state law claims which could be maintained on behalf of potential class members whose insurance certificates are not controlled by ERISA. We REMAND this case to the district court for further proceedings consistent with this opinion.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

MEMORANDUM OF DECISION

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
	)	Case No. 1:90 CV 1483
vs.	)	
	)	Judge Alice M. Batchelder
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	

MEMORANDUM OF OPINION AND ORDER

I. Introduction and Background

Plaintiff was prescribed by his doctor to undergo outpatient Phase II Cardiac Rehabilitation services following a coronary procedure. The rehabilitation therapy is designed to strengthen the heart and circulatory system, and to restore maximum function to the heart. Plaintiff submitted a claim for these services to his medical insurer, Blue Cross & Blue Shield Mutual of Ohio (BCBSO), but BCBSO refused to pay the claim.

Plaintiff seeks to bring this cause of action as a class

action suit against BCBSO and its subsidiaries on behalf of Blue Cross subscribers who have "Therapy Services" listed in their Certificates of Coverage, who have been prescribed to undergo Phase II Cardiac Rehabilitation, and who have not had their actual or potential Phase II therapy charges paid by BCBSO. Plaintiff brings a claim to recover benefits and a claim for breach of fiduciary duty under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq., as well as several state law claims.

Plaintiff seeks a declaration that Cardiac Rehab is a covered service for these subscribers; a preliminary and permanent injunction; and damages and punitive damages.

This matter is before the Court on plaintiff's motion and amended motion for class certification (Doc. Nos. 23 & 31); defendant's motion for partial judgment on the pleadings (Doc. No. 28); plaintiff's motion for leave to amend complaint (Doc. No. 32); plaintiff's motion to compel discovery (Doc. no. 48); and plaintiff's motion for preliminary injunction (Doc. no. 2).

II. Class Certification

Plaintiff filed a motion for class certification on

April 30, 1991.[1] On July 17, 1990, plaintiff filed an amended motion for class certification. In that amended motion, Plaintiff requested that the class be defined as:

> 1. All persons who, since August 17, 1985 have been or are subscribers, covered persons, or otherwise entitled to health care insurance coverage under a contract of insurance offered or administered by Defendant, Blue Cross & Blue Shield Mutual of Ohio, or one of its subsidiaries, predecessors or successors in interest ("BCBSO");
>
> 2. Who have a Certificate of Coverage which specifically provides coverage for "Therapy Services" and does not specifically include or exclude Phase II Cardiac Rehabilitation; and
>
> 3. Who were or are prescribed by a licensed physician to undergo Phase II Cardiac Rehabilitation therapy because they have or had one of the following conditions or are to or have undergone one of the following procedures
>
> (a) myocardial infarction;
>
> (b) coronary artery bypass surgery for coronary

---

[1]Plaintiff's original motion for certification of the class described a class consisting of all Blue Cross subscribers who were prescribed to undergo Cardiac Rehab services, not just such subscribers who have Certificates of Coverage for "Therapy Services".

artery disease;

(c) stable angina pectoris;

(d) documented myocardial ischemia by stress testing or electrocardiography in patients with coronary artery disease;

(e) status post heart valve repair or replacement;

(f) post coronary angioplasty;

(g) post cardiac transplantation;

(h) cardiomyopathy; and

4. Who have not had their actual Phase II Cardiac Rehabilitation therapy charges paid by BCBSO or have not had their potential cardiac rehabilitation therapy charges approved for payment by BCBSO. (Amended Motion to Certify Class, at 1-2)

In ruling on a motion for class certification, the Court is not to look at the merits of plaintiff's claim, but is merely to determine if the class meets the requirements of Rule 23. Huff v. N.D. Cass Co. of Ala., 485 F.2d 710, 714 (6th Cir. 1973) (*en banc*) ("a class plaintiff who otherwise meets the demands of 23(a) and (b) should not be found to be disqualified solely by an advance determination that his claim is predictably not a winning claim.") The requirements for maintaining a class action include:

(1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of

> law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). In addition, the plaintiff must prove one of the following four elements:

(1) that prosecution of separate actions by individual members of the class would create the risk of inconsistent judgments establishing incompatible standards of conduct for the party opposing the class, Fed. R. Civ. P. 23(b)(1)(A);

(2) that the prosecution of separate actions by individual members of the class would create a risk of judgments as to individual members of the class that would be dispositive of the interests of, or substantially impair or impede their ability to protect the interests of, members not parties to the adjudication, Fed. R. Civ. P. 23(b)(1)(B);

(3) the party opposing the class has acted or refused to act on grounds generally applicable to the class, making appropriate final injunctive relief or corresponding declaratory relief with respect to the class a whole, Fed. R. Civ. P. 23(b)((2); or

(4) questions of law or fact common to the members of the class predominate over any questions

affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. Fed. R. Civ. P. 23(b)(3).

This Court has broad discretion in determining whether a particular action complies with Rule 23. Sterling v. Velsicol Chemical Corp., 855 F.2d 1188, 1197 (6th Cir. 1988). In using its discretion, courts are not to apply the requirements of Rule 23 so strictly that the policies underlying class actions are undermined. Weathers v. Peters Realty Corp., 499 P.2d 1197, 1200 (6th Cir. 1974).

The Court must first determine if the proposed class is of sufficient definiteness to be characterized as a class. Wright & Miller, Federal Practice & Procedure, § 1760, at 115-121 (1986). The proposed class must not be overly broad, too indefinite or amorphous. See Hendrickson v. Philadelphia Gas Works, 672 F. Supp. 823, 841 (E.D. Pa 1987) ("these proposed classes are so amorphous and broad as to defy definition").

The class that plaintiff has proposed is both vague and overly broad. Plaintiff's requested class consists of all those Blue Cross/Blue Shield subscribers who have the language "Therapy Services" in their Certificates of Coverage. However, as is clear from plaintiff's Certificate

of Coverage, "Therapy Services" is merely a heading under which covered services are listed. This is evident from the language underneath the "Therapy Services" heading: "Services or supplies used to promote recovery from an illness or injury include. This language indicates that the items listed below the heading are the services that BCBSO covers as services designed to promote recovery from an illness or injury. The heading is not a guarantee to subscribers that any and all therapy services promoting recovery from illness will be covered. As shown in defendants Appendix to its Brief in Opposition to Amended Motion for Class Certification, the services listed under "Therapy Services" differ from certificate to certificate, just as they do under other headings such as "Diagnostic Services." Therefore, a class of subscribers consisting of all those whose contracts include the "Therapy Services" heading is both overly broad and nonsensical.

This Court, however, has the discretion to redefine the class or construe the complaint to bring it within the scope of Rule 23. Geraghty v. United States Parole Comm'n, 719 P.2d 1199, 1205 (3d Cir. 1983) (confining class to those imprisoned in Middle District of Pennsylvania), cert. denied, 465 U.S. 1103, 104 S. Ct. 1602 (1984); Schuler v. Better Equip. Launder Center, Inc., 74 F.R.D. 85, 88 (D. Mass 1977) (narrowing scope of class involving franchise contracts); Wright & Miller, Federal

Practice & Procedure, § 1759, at 112 (1986).

In this case, plaintiff's motion for class certification indicated that the Court's inquiry should focus on the interpretation of the language "Treatment by Physical Means" contained in his Certificate of Coverage under the "Therapy Services" heading. (Plaintiff's motion to Certify Class, at 10).[2]

---

[2] Defendant contends that plaintiff abandoned his original theory involving "treatment by physical means" outlined in his motion to certify with his amended motion to certify. Plaintiff submits that he did not abandon his argument based on the "treatment by physical means" language by amending his motion to certify to create a class of subscribers with "Therapy Services" coverage. Plaintiff explained that he amended his motion for class certification because some Certificates of Coverage are not identical to plaintiff's in the wording of the "treatment by physical means" clause. "Rather than dispute over semantics, Plaintiff has amended his class definition to include all persons who have certificates of coverage which have coverage for "Therapy Services" because "Therapy Services" is the broader category, including (sic] within its scope 'treatment by physical means'" (Plaintiff's Reply Brief, at 2).

Resolution of this dispute is not necessary because this Court has the discretion to construe a complaint to redefine a class even if the plaintiff has not presented that, precise class to the Court for class certification.

That language reads:

> Treatment by Physical Means -- The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical and neurophysiological principles and devices.
>
> The number of visits which your coverage provides is specified in the Schedule of Benefits. We may approve additional treatments, however, if your Physician or Professional Other Provider explains in writing the reason for more treatments and we determine that they are Medically Necessary.

Identical or similar language is used in many other Certificates of Coverage, while some certificates merely state that "Treatment by Physical Means" is covered but do not define the term.

Even if the Court were to construe the complaint to create a class of subscribers with "Treatment by Physical Means" language, such a class would not meet all the requirements of Rule 23, as is indicated below.

1. Numerosity

The plaintiff has the burden of showing that the

class is so numerous that joinder of all members is impracticable. Fed. R. Civ. P. 23(a)(1). Plaintiff could meet this requirement. A plaintiff need not show the exact number of members making up the class. See Doe v. Charleston Area Medical Center, 529 F.2d 638, 645 (4th Cir. 1975) (informal survey showed 70 women per month went outside area to terminate pregnancies); Wright & Miller, Federal Practice & Procedure, § 1762, at 160 (1986). In his Motion to Certify Class, plaintiff indicates that at least 3,672 people each year are cardiac rehab patients covered by BCBSO, or 18,360 over a five-year period. This number obviously meets the numerosity requirement.

2. Adequacy of Representation

The representative must also fairly and adequately protect the class's interests. Fed. R. Civ. P. 23(a)(4). The Court agrees that the plaintiff could also meet this requirement. Adequacy of representation requires that the "party's attorney be qualified, experienced and generally able to conduct the proposed litigation," and that the representatives interests not be antagonistic to those of the class. Eisen v. Carlisle & Jacquelin, 391 P.2d 555,, 562 (2d Cir. 1968). The representative must be of such a character as to assure vigorous prosecution of the action, and his lawyer must be willing and able to vigorously prosecute the action. Wright & Miller, supra, § 1766, at 303, § 1769.1,

at 375. The affidavits submitted by plaintiff and his counsel indicate that this requirement has been met. (Plaintiff's Motion to Certify Class, at Appendix).

3. Commonality

The plaintiff must also show that there are questions of law or fact common to the class. Fed. R. Civ. P. 23(a)(2). In general, courts apply this requirement permissively, even if factual differences between class members exist. Stewart v. Winter, 669 F.2d 328, 335 (5th Cir. 1982) (there must be "at least one issue whose resolution will affect all or a significant number of the putative class members."); Like v. Carter, 448 P.2d 798, 802 (8th Cir. 1971) ("factual differences are not fatal), cert. denied, 405 U.S. 1045, 92 S. Ct. 1309 (1972); Wright & Miller, Federal Practice & Procedure, § 1763, at 199 (1986). But see Rettig v. Dent City School Dist., 94 F.R.D. 12, 14 (N.D. Ohio 1980) (denying class certification for handicapped school children because no common questions of fact or law existed). This case involved individual issues regarding each group contract. Yet, the Court will view 23(a)(2) liberally and assume that common issues exist, such as the meaning of "treatment by physical means" and whether Cardiac Rehab is a covered service.

4. Typicality

The claims of plaintiff must be typical of the claims

of the class. Fed. R. Civ. P. 23(a)(3). A class based on the "Treatment by Physical Means" language does not meet this requirement. This provision requires that the representatives claims be similar enough to the claims of the class so that he will adequately represent them. Wright & Miller, supra, § 1764, at 232-33. "The typicality requirement of Rule 23(a)(3) requires that the Court scrutinize the individual claim of the plaintiff and determine if it has the characteristics common to the claims of the class." Roundtree v. Cincinnati Bell, Inc., 90 F.R.D. 7, 9 (S.D. Ohio 1979). Although the claims of the class members need not be identical, United Independent Flight Officers, Inc. v. United Air Lines, Inc., 572 F. Supp. 1494, 1499 (N.D. Ill 1983), aff'd, 756 F.2d 1274 (7th Cir. 1985), the representative's claims are not typical of the classes unless his claims "arise from the same practice or course of conduct and are based on the same legal theory." Basile v. Merrill, Lynch, Pierce, Fenner & Smith, Inc., 105 F.R.D. 506, 508 (S.D. Ohio 1985); Wright & Miller, supra, § 1764, at 235-41. As the court held in Brown v. Orr, 99 F.R.D. 524, 527 (S.D. Ohio 1983), plaintiff "failed to establish that she was not promoted for reasons typical to every other class member. The Court concludes that there are simply too many factual distinctions to be made with respect to each claim, to warrant a determination that Plaintiff's claim is 'typical' of all other claims." Id. Here, the typicality requirement has not been met because, as set

out below, plaintiff's a claim arises out of the negotiations between BCBSO and his insurance group, the Council of Smaller Enterprises (COSE). The Certificates of Coverage for each group result from the specific negotiations between that group and BCBSO. While plaintiff 's claim may be typical of those of other members of his own group, because the same insurance contract covers each of the group members and resulted from the same negotiations between The Council of Smaller Enterprises and BCBSO, plaintiff's claims cannot be said to be typical of those of other groups' members who are covered by separate insurance contracts resulting from wholly separate and different negotiations between other groups and BCBSO.

5. Requirement of 23(b)

Even if a class based on the "Treatment by Physical Means" language survived the typicality requirement, such a class does not fit into any category under 23(b). This proposed class clearly does not fit into 23(b)(1)(A) or 23(b)(1)(B) because BCBSO would not be subject to inconsistent standards of conduct if individual suits were brought, In re Bendectin Prods. Liability Litigation, 749 F.2d 300, 305 (6th Cir. 1984) (fact some plaintiffs will prevail against defendants and others may not is not sufficient), nor are subscribers, claims at risk because of a limited BCBSO fund, Zeffiro v. First Pennsylvania Banking & Trust Co., 96 F.R.D. 567, 573 (E.D. Pa. 1983).

This class also would not meet 23(b)(2), a section especially suited to civil rights actions. Two factors must be met to establish a class under 23(b)(2): 1) the opposing party's conduct or refusal to act must be on grounds "generally applicable" to the class and 2) final injunctive or corresponding declaratory relief must be requested for the class. Wright & Miller, supra, § 1775, at 447-48. The party opposing the class must either have acted in a "consistent manner toward members of the class so that his actions may be viewed as part of a pattern of activity, or. . . acted pursuant to a regulatory scheme common to all class members. Id. at 449. Here, defendant does routinely deny Cardiac Rehab coverage unless it is specifically included in a Certificate of Coverage. (Defendant's Answers to Interrogatories No. 4, 18, 20, Plaintiff's Exhibit E, Motion to Certify Class). However, the grounds for denying the claims revolve around the specific negotiations between BCBSO and each particular group. Therefore, defendant's actions are not on grounds generally applicable to all class members; they are on grounds specific to each group's bargaining process with BCBSO.

The category into which the proposed class ostensibly might fit is 23(b)(e). Neither, however, can the proposed class meet the requirements of this provision, which requires that:

> the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that the class action is superior to other available methods for the fair and efficient adjudication of the controversy.

Fed. R. Civ. P. 23(b)(3). This Court cannot say that in this case the common questions of law and fact predominate over questions affecting only individual members.

Defendant misstates the law in implying that federal courts have not upheld class actions in cases involving contracts. See In re: Energy Systems Equip. Leasing Sec. Litigation, 642 P. Supp. 718, 751-52 (E.D.N.Y. 1986) (class involving lease and service agreements appropriate for class certification; Joseph v. Norman's Health Club, Inc., 336 P. Supp. 307, 318 (E.D. Mo. 1971) (class approved for persons who signed promissory notes for lifetime memberships); Ingram v. Joe Conrad Chevrolet, 90 F.R.D. 129, 13334 (E.D. Ky. 1981) (class certified for consumers who purchased cars using contract similar to named party's). "This is not to say that breach of form contract suits are susceptible to class treatment in all cases." Kleiner v. First Nat'l Bank of Atlanta, 97 F.R.D. 683, 693 (N.D. Ga. 1983). In contract cases in which classes have been certified, the courts either did not need to look beyond

the objective meaning of the contract language or the common issues predominated over individual questions.

That simply is not the case here. The language in plaintiff's certificate describing "Treatment by Physical Means" includes the terms "physical treatments" and "physical agents," but does not define these phrases. This language in plaintiff's certificate is not only ambiguous; it is unintelligible. Because the clause is clearly ambiguous, parol evidence must come in to clarify what the parties to the contract intended by this language. See Kleiner v. First Nat'l Bank of Atlanta, 97 F.R.D. 683, 693 (N.D. Ga. 1983.) ("parol evidence of the parties, subjective intent, or of a prior course of dealings, would be inadmissible unless the contract were patently ambiguous"); Carroll Weir Funeral Home, Inc. v. Miller, 2 Ohio St.2d 189, 207 N.E.2d 747, 749 (1965).

The need to bring in parol evidence is complicated by the fact that BCBSO offers a wide variety of Certificates of Coverage. (See Appendix to Defendant's Brief in Opposition to Amended Motion for Class Certification). This is evidenced by the fact that at least one of the Certificates of Coverage specifically covers Cardiac Rehabilitation under the "Therapy Services" heading. (See Appendix, Exhibit E, at 16). Although individual subscribers may not have been involved in negotiating the

benefits they receive from BCBSO, the group to which they belong has the duty to negotiate for its subscribers, benefits. To rule on the meaning of an ambiguous term such as "Treatment by Physical Means," the Court would have to consider parol evidence concerning the negotiations between BCBSO and each insurance group. This would require an individualized inquiry into such issues as what the group negotiators believed "Treatment by Physical Means" included, what the parties discussed, and what insurance packages were presented to each group. Thus, the issue in this case cannot be viewed, Os the plaintiff suggests, as merely one of abstract contract interpretation. It is possible to say that the common questions predominate when the negotiations of each individual group must be explored in order to resolve the meaning of the ambiguous language. Neither can this Court say that the class action is the superior method for resolving such fact-specific inquiries as individual negotiations.

6. Conclusion

A class encompassing certificates containing "Therapy Services" language is overly broad. And, even if the Court were to construe plaintiff's complaint to create a class under the "Treatment by Physical Means" language, such a class could not meet Rule 23's requirements. However, this Court grants plaintiff leave to amend his motion to certify class to set out a lesser class, such as class

of COSE subscribers, in which this Court would need only consider the negotiations between BCBSO and the group that negotiated plaintiff's Certificate of Coverage to rule on the ambiguous "Treatment by Physical Means" language.

III. Leave to Amend Complaint

Plaintiff has filed leave to amend his complaint to limit the class to subscribers who have certificates containing "Therapy Services" language. In light of the Court's ruling on class certification, this motion is DENIED as moot. The Court grants plaintiff leave to amend his complaint either to delete references to a class action and to proceed individually or, in conjunction with an amended motion to certify a class, to create a lesser class of subscribers who have coverage under a contract negotiated by the same parties.

IV. Motion for Partial Judgment on the Pleadings

Defendant has filed a motion for partial judgment on the pleadings regarding several of plaintiff's state law claims. Plaintiff's proposed amended complaint sought to eliminate four of the original state law claims. Under the proposed complaint, only three state law claims remain, and plaintiff indicated he would confine those claims to either those subscribers not subject to ERISA or those covered by

ERISA but not participants in self-funded health plans. This Court has granted plaintiff leave to file an amended complaint to proceed individually or as a lesser class. Defendant's motion is denied, but without prejudice to its being renewed once plaintiff has filed this amended complaint.

V. Motion to Compel

Plaintiff has a filed a motion to compel discovery from defendant concerning plaintiff's third set of interrogatories and document requests. Most of the interrogatories seek to obtain from BCBSO information relating to subscribers with the "Therapy Services" heading contained in their Certificates of Coverage.

This Court's ruling above on class certification found that "Therapy Services" is merely a heading and that a class defined by such a heading is overly broad and amorphous. In addition, the Court has held that a class defined by the language of "Treatment by Physical Means" will not be certified. In light of this ruling, the Court finds that the motion to compel must be denied because the material sought is not relevant either to plaintiff's individual claim or any class action of a lesser size that plaintiff may propose and this Court would accept. These interrogatories seek information on subscribers who have certificates that

were not negotiated by the parties who negotiated plaintiff's group certificate. Therefore, information related to other contracts is not relevant. In addition, BCBSO has agreed to supplement Interrogatory No. 11, and therefore, the motion as to that interrogatory is premature.

VI. Preliminary Injunction

Plaintiff has filed a motion for preliminary injunction in this matter. This Court finds that a separate preliminary injunction hearing at this point would not be worthwhile. Pursuant to Federal Rule of Civil Procedure 65, this Court orders the hearing of the application for preliminary injunction to be advanced and consolidated with the trial of the suit on the merits.

VII. Scheduling

This Court previously granted a request of the parties for a continuance of the trial date and other deadlines set in the Pre-Trial Order. After plaintiff has submitted an amended complaint and/or an amended motion to certify class, this Court will reset deadlines for the items listed in the Pre-Trial Order.

VIII. Conclusion

For the reasons set out above, this Court finds that the motion and amended motion for class certification are DENIED; plaintiff's leave to amend complaint is DENIED as moot; the Court grants plaintiff leave to amend his complaint in light of the Court's ruling on the class certification issue; defendant's motion for judgment on the pleadings is DENIED as moot, but such motion may be renewed following plaintiff's filing of his amended complaint; and plaintiff is motion to compel is DENIED. The hearing on plaintiff's application for preliminary injunction is consolidated with the trial on the merits. The Court will enter a new Pre-Trial Order once plaintiff has submitted his amended complaint and/or amended motion to certify class.

IT IS SO ORDERED.

Dated this 6th day of December, 1991.

/s/ ALICE M. BATCHELDER
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

MEMORANDUM OF OPINION AND ORDER

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
	)	Case No. 1:90 CV 1483
vs.	)	
	)	JUDGE PAUL R. MATIA
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	

MEMORANDUM OF OPINION AND ORDER

This action is before the Court upon (1) defendants' motion to strike plaintiff's second amended complaint (Doc. #63); (2) plaintiffs' notion for leave to file second amended complaint (Doc. #65); and, (3) plaintiff's motion for reconsideration of December 6, 1991 Order (Doc. #67). The Court has considered the memoranda in support, the memoranda in opposition and plaintiff's reply. The Court has also reviewed the substantive issues in the case at bar and the evidence related to them.

A class action complaint for preliminary and permanent injunction and other relief and a motion for

preliminary injunction were filed on August 17, 1990. Plaintiff alleged that defendants, Blue Cross & Blue Shield Mutual of Ohio, et al. ("Blue Cross") wrongfully denied his request for payment in the approximate amount of $2,300.00 for "Phase II Cardiac Rehabilitation Services" ("Cardiac Rehab"). Blue Cross argues that the instant case was filed to force Blue Cross to provide coverage for "a new product recently created by hospitals" to provide a package of services for their heart patients.[1] Plaintiff's claim involves an interpretation of a particular "Covered Service" contained in his Certificate of Insurance offered through the Council of Small Enterprises ("COSE"). The Certificate states as follows:

> **Therapy Services**
>
> Services or supplies used to promote recovery from an illness or injury include:
>
> * * * *
>
> **Treatment by Physical Means** -- The treatment given to relieve pain, **restore maximum function**

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[1]"Cardiac Rehab" is a group of different services packaged together by health care providers. It may include x-rays, laboratory work, stress testing and supervised and monitored counselling and educational or training programs to educate the patient about changes in his or her lifestyle.

and to prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical or neurophysiological principles and devices.

* * * *

Id. at 9-10. (Emphasis added.)

On December 6, 1991, after considerable discovery and briefing had been conducted on the class certification issue, District Judge Alice M. Batchelder issued a seventeen page Memorandum of Decision ("Memorandum") in the case at bar.[2] Provides in pertinent part:

6. Conclusion

A class encompassing certificates containing "Therapy Services" language is overly broad. And, even if the Court were to construe plaintiff's complaint to create a class under the "Treatment by Physical Means" language, such a class could not

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[2]The within matter was originally assigned to District Judge Batchelder. Judge Batchelder was appointed United States Circuit Court Judge for the Sixth Circuit on June 12, 1991, and entered on duty January 4, 1932. On December 20, 1991, the case was transferred to the undersigned.

meet Rule 23's requirements. However, this Court grants plaintiff leave to amend his motion to certify class **to set out a lesser class, such as [a] class of COSE subscribers**, in which this Court would need only consider the negotiations between BCBSO and the group that negotiated plaintiff's Certificate of Coverage to rule on the ambiguous "Treatment by Physical Means" language.

III. Leave to Amend Complaint

Plaintiff has filed leave to amend his complaint to limit the class to subscribers who have certificates containing "Therapy Services" language. In light of the Court's ruling on class certification, this motion is DENIED as moot. **The Court grants plaintiff leave to amend his complaint either to delete references to a class action and to proceed individually or, in conjunction with an amended motion to certify a class, to create a lesser class of subscribers who have coverage under a contract negotiated by the same parties.**
Id. at 14. (Emphasis added.)

The Court did not set a deadline for filing the amended complaint.

Plaintiff subsequently filed a second amended class action complaint for permanent injunction and other relief (Doc. #60) on March 20, 1992. The second amended complaint adds a new party plaintiff, Alan Peters, who alleges that he "was the policyholder of a BCBSO Certificate of Insurance not obtained through COSE." Id. at ¶8. He has incurred approximately $700.00 for Cardiac Rehab. The new class definition narrowed the class from those with "Therapy Services" to those with "Treatment by Physical Means," which is a subgroup under "Therapy Services." Any group which used the specific term "Cardiac Rehabilitation" in its Certificate was also excluded from the class. The new class definition admittedly does not "create a lesser class of subscribers who have coverage under a contract negotiated by the same parties," i.e., COSE and Blue Cross. Id. at ¶20. See, also, Plaintiff's Memorandum at 19-20.

On March 27, 1992, the instant case came on for a status call. Pursuant to the agreement of lead counsel of record, defendants were given until April 10, 1992 to file a motion to strike the second amended class action complaint. Plaintiff was given until April 20, 1992 to file a memorandum in opposition to defendants' motion. Defendants timely filed their motion to strike. Plaintiff, however, in addition to filing his memorandum in opposition to the motion to strike, filed a motion for leave

to file second amended complaint and a motion for reconsideration of December 6, 1991 Order.[3]

Plaintiff argues that the Memorandum is based upon "improper or uninformed factual assumptions." Plaintiff's Memorandum at 23. Plaintiff contends that the Memorandum assumed the existence of negotiations and discussion concerning Cardiac Rehab which did not exist. Defendants disagree that this is a new fact and cite paragraph 9 of the July 17, 1991 affidavit of John J. Polk, the Executive Director of COSE. Defendants contend that the Court was aware of the lack of discussions concerning Cardiac Rehab during the COSE and Blue Cross negotiations because plaintiff submitted the Polk affidavit to the Court as Exhibit "All to his Amended Motion for Class Certification, filed on July 17, 1991.

As District Judge Sam H. Bell stated in Kuenz v. Goodyear Tire & Rubber Co., 617 F. Supp. 11 (N.D. Ohio 1985),

While the court has the power to modify or vacate

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[3]Blue Cross requests leave to file a memorandum in opposition to the merits of plaintiff's memorandum of the points and authorities on which he relies in support of his motion for reconsideration, if the Court determines that it will consider plaintiff's contentions on the merits.

an order previously entered in the same case by any judge to whom it was assigned and is not precluded from such action by 'law of the case' principles, exercise of this power must of necessity be used sparingly. When issues have been carefully considered and decisions rendered, the only reason which should commend reconsideration of that decision is a change in the factual or legal underpinnings upon which the decision was based. For reasons of policy, courts and litigants cannot be repeatedly called upon to backtrack through the paths of litigation which are often laced with close questions.

Decisions, once made in full consideration,of complete records during the course of litigation, deserve the badge of dependability necessary to advance the case to the next stage. During the course of its progress, the court maintains the ability to modify previous orders when a new fact or legal premise is brought to light. This is especially true on the issue of class certification as provided by Federal Rule of Civil Procedure 23(c)(1). Id. at 13-14.

See also Cale v. Johnson, 861 F.2d 943, 947-48 (6th Cir. 1988). The Court finds no change in the factual or legal

underpinnings upon which the Memorandum was based which would justify reopening what has already been decided by Judge Batchelder. Accordingly, the Court will not reconsider the December 6, 1991 Order. See also Fed. R. Civ. P. 23(d)(1).[4]

For the foregoing reasons, defendants' motion to strike plaintiff's second amended complaint (Doc. 163) is GRANTED. Plaintiff's second amended class action complaint for permanent injunction and other relief (Doc. #60), filed on March 20, 1992, is stricken from that file.

In light of the Court's ruling on defendants' motion, plaintiff's motion for leave to file second amended complaint (Doc. #65) is DENIED. This case will now be advanced to the next stage. Therefore, on or before April 1, 1993, plaintiff shall file an amended complaint that either deletes references to a class action or, in conjunction with an amended motion to certify a class, creates a lesser

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[4]Fed. R. Civ. P. 23(d)(1) provides:

> In the conduct of actions to which this rule applies, the court may make appropriate orders: (1) determining the course of proceedings or prescribing measures to prevent undue repetition or complication in the presentation of evidence or argument . . . .

class of subscribers who have coverage under a contract negotiated by the same parties.

Plaintiff's motion for reconsideration of December 5, 1991 Order (Doc. #67) is DENIED.

IT IS SO ORDERED.

Paul R. Matia
UNITED STATES DISTRICT JUDGE

APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

MEMORANDUM OF OPINION AND ORDER
[RE: REGARDING PLAINTIFF'S SECOND
AMENDED MOTION FOR CLASS
CERTIFICATION]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
	)	Case No. 1:90 CV 1483
vs.	)	
	)	JUDGE PAUL R. MATIA
BLUE CROSS AND BLUE SHIELD OF OHIO, et al.	)	
Defendants.	)	

MEMORANDUM OF OPINION AND ORDER

I. Introduction and Background

This action is before the Court upon plaintiff's Second Amended Motion for Class Certification ("Second Amended Motion") (Doc. #82).[1] Plaintiff underwent

[1]The court has also considered defendant's Brief in Opposition. For this certification issue, lead counsel of record requested and the court ordered that Plaintiff would file a second amended motion and defendant would file a brief in opposition. Plaintiff's Motion for Leave to File a Reply to Defendant's Brief in Opposition to Plaintiff's Second Amended Motion for Class certification (Doc. #87)

Rehab") following a coronary procedure in 1990. Plaintiff alleges that his medical insurer, defendant Blue Cross & Blue Shield of Ohio ("BCBSO"), wrongfully denied his request for reimbursement for the costs of the Cardiac Rehab, which amounted to approximately $2,300.00. BCBSO asserts that Cardiac Rehab is only a covered benefit when specifically mentioned in the Certificate of Coverage. Plaintiff's Certificate of Coverage does not explicitly mention Cardiac Rehab as a covered benefit. Thus, defendant asserts, plaintiff's claim for reimbursement was rightfully denied. Since the language of plaintiff's Certificate of Coverage is clearly ambiguous, it is necessary for this court to analyze parol evidence, including negotiations between BCBSO and the group that negotiated plaintiff's Certificate of Coverage, in order to determine whether the parties intended Cardiac Rehab to be covered.

Plaintiff seeks to bring this action as a class action suit against: BCBSO and its subsidiaries. Plaintiff's original Motion to Certify Class (Doc. #23) ("Original Motion"), filed April 30, 1991, proposed a class consisting of all BCBSO subscribers who were prescribed to undergo Cardiac Rehab. Original Motion at 1-2. On July 17, 1990, plaintiff filed an Amended Motion for Class Certification (Doc. # 31) ("Amended Motion") which restricted the

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was denied by marginal entry.

proposed class to subscribers who have Certificates of Coverage which include "Therapy Services." Amended Motion at 1-2.

In her Memorandum of Decision issued December 9, 1991 ("Memorandum"), District Judge Batchelder stated that this class definition was overly broad. Further, District Judge Batchelder stated that even if the class were narrowed to include only BCBSO subscribers whose certificates of service contained the language "Treatment by Physical Means," certification of the class would still be inappropriate under Fed. R. Civ. P. 23.

> Thus, District Judge Batchelder denied plaintiff's Amended Motion to Certify a Class but granted plaintiff leave to amend his complaint either to delete references to a class action and to proceed individually or, in conjunction with an amended motion to certify a class, to create a lesser class of subscribers who have coverage under a contract negotiated by the same parties.

Memorandum at 14. District Judge Batchelder stated that in order to meet the requirements of Fed. R. Civ. P. 23, plaintiff would have to define a class in which the court "Would only need to consider the negotiations between BCBSO and the group that negotiated plaintiff's Certificate

of Coverage to rule on the ambiguous 'Treatment by Physical Means' language." Id. District Judge Batchelder also suggested that a class which consisted only of those who subscribed to BCBSO through COSE might be appropriate for certification.

II. Class Certification

Plaintiff filed a Second Amended Motion to Certify a Class (Doc #82) on April 1, 1993. In accordance with District Judge Batchelder's suggestion, plaintiff further restricted the proposed class to include only those BCBSO subscribers whose insurance was issued pursuant to an agreement with COSE. The class proposed in the Second Amended Motion in defined an follows:

> 1. All persons who, since August 17, 1985 have been or are subscribers, covered persons, or otherwise entitled to health care insurance coverage under a contract of insurance offered or administered by Defendant, Blue Cross & Blue Shield Mutual of Ohio, or one of its subsidiaries, predecessors or successors in interest ("BCBSO") which is issued pursuant to an agreement between BCBSO and the council of Smaller Enterprises ("COSE"); and

2. Who have a Certificate of Coverage which specifically provides coverage for "Treatment by Physical Means" and does not specifically include or exclude Phase II Cardiac Rehabilitation; and

3. Who have been prescribed by a licensed physician to undergo Phase II Cardiac Rehabilitation therapy because they have or had one of the following conditions or are to have undergone one of the following procedures:

(a) myocardial infarction;
(b) coronary artery bypass surgery for coronary artery disease;
(c) stable angina pectoris;
(d) documented myocardial ischemia by stress testing or electrocardiography in patients with coronary heart disease;
(e) status post heart valve repair or replacement;
(f) post coronary angioplasty;
(g) post cardiac transplantation;
(h) cardiomyopathy; and

4. Who have not had their actual Phase II Cardiac Rehabilitation therapy charges paid by BCBSO or have not had their potential cardiac

> rehabilitation therapy charges approved for payment by BCBSO.

Second Amended Motion at 1-2 (emphasis added).

The requirements for maintaining a class action include:

> (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). In addition, the plaintiff must prove one of the following four elements of Rule 23(b):

(1) the prosecution of separate actions by individual members of the class would create the risk of inconsistent judgments establishing incompatible standards of conduct for the party opposing the class, Fed. R. Civ. P. 23 (b) (1) (A);

(2) the prosecution of separate actions by individual members of the class would create a risk of judgments as to individual members of the class which would as a practical

matter be dispositive of the interests of, or substantially impair or impede their ability to protect the interests of, members not parties to the adjudication, Fed. R. Civ. P. 23(b)(1)(B);

(3) the party opposing the class has acted or refused to act on grounds generally applicable to the class, making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole, Fed. R. Civ. P. 23(b)(2); or

(4) questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. Fed. R. Civ. P. 23(b)(3).

1. Adequacy of Representation

Rule 23(a)(4) dictates that the class representative and his/her counsel must fairly and adequately protect the class's interests. After an examination of the affidavits contained in the appendix of plaintiff's Motion to Certify a Class, District Judge Batchelder asserted that plaintiff and his counsel met this requirement. Memorandum at 8.

The parties again argued the adequacy issue in the Second Amended Motion to Certify a Class and Brief in opposition. Neither party, however, presented any new facts or issues regarding the adequacy of plaintiff as representative or his counsel as advocate. Therefore, District Judge Batchelder's holding of adequacy will stand as the law of this case.

2. Commonality

Rule 23(a)(2) requires plaintiff to show that there are questions of law and fact common to the class. District Judge Batchelder determined that even with a broader class containing all BCBSO subscribers, sufficient common questions were raised to meet the commonality requirement of Rule 23(a). "[This] Court will view 23(a)(2) liberally and assume that common issues exist, such as the meaning of 'treatment by physical means' and whether Cardiac Rehab is a covered service." Memorandum at 8-9.

Plaintiff's second Amended Motion contains a narrower class definition, and thus fewer discrepancies among class members exist. Therefore, the commonality requirement will again be met by plaintiff's Second Amended Motion.

3. Typicality

Plaintiff must also demonstrate that his claims are typical of the claims of the class. District Judge Batchelder held that the class proposed by plaintiff in his Amended Motion, which included all BCBSO subscribers, did not meet the typicality requirement. Since COSE's negotiations for coverage were separate and distinct from other groups' negotiations, there were simply "too many factual distinctions . . . to warrant a determination that plaintiff's claim is 'typical' of all other claims." Memorandum at 9-10, citing Brown v. Orr, 99 F.R.D.524, 527 (S.D. Ohio 1983).

District Judge Batchelder suggested that a restriction of the class to only those in plaintiff's insurance group that had negotiated with BCBSO might solve this deficiency in plaintiff's class definition. Memorandum at 10. Thus, the court granted plaintiff leave to amend his motion to create a class "in which this Court would only need consider the negotiations between BCBSO and the group that negotiated plaintiff's Certificate of Coverage to rule an the ambiguous "Treatment by Physical Means" language." Memorandum at 14 (emphasis added).

The class proposal in the Second Amended Motion fails to meet this directive, and thus again fails to meet the typicality requirement under Rule 23 and the law of this

case. In its Brief in opposition, defendant proffers uncontested evidence regarding the process by which plaintiff obtained his BCBSO insurance. First, BCBSO entered into a master contract with COSE for insurance coverage. Plaintiff and defendant have agreed that there were no negotiations between COSE and BCBSO in which the parties specifically discussed coverage for Cardiac Rehab. See, defendant's Brief at 6; plaintiff's Memorandum in Support of Plaintiff's Motions for Leave to File Second Amended Complaint, for Reconsideration of December 6, 1991 Order, and in Opposition to Defendant's Motion to Strike at 7.

Second, each COSE member group contacts BCBSO and discusses which (if any) of the coverage plans in the master contract the member group has selected. Brief in Opp. at 7. Each member group has discussions with BCBSO prior to entering into a contract for insurance coverage. Id. at 8. Santoli Aff. at ¶5.

Insurance is sold directly by BCBSO to the member company. Neither COSE nor GSI[2] sell BCBSO

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[2]GSI is an Ohio non-profit corporation whose sole member is the Greater Cleveland Growth Association. The Greater Cleveland Growth Association, of which COSE is a division, is a non-profit organization which serves as a Chamber of Commerce for Greater Cleveland.

> policies to COSE members. COSE makes the names of its various members available to BCBSO. Members contract directly with BCBSO for the particular policy they choose to elect.

Polk Aff. at ¶6 (emphasis added.)

Therefore, three parties were involved in the negotiations for plaintiff's Certificate of Coverage; BCBSO, COSE, and plaintiff's employer, COSE member group Dallas Warehouse. Consequently, in order to determine the terms of plaintiff's Certificate of Coverage, this Court must look beyond the negotiations between BCBSO and COSE for the master contract. It is also necessary to examine any communications Dallas Warehouse had with BCBSO prior to purchasing insurance coverage for plaintiff and other Dallas Warehouse employees.

The proposed class, however, is not restricted to employees of Dallas Warehouse. Thus, in order to examine those parol evidence relating to the insurance contracts of all class members, this court would need to review not only the negotiations between COSE and BCBSO, but also the communications each COSE member group had with BCBSO prior to the direct purchase of the insurance contract. Thus, plaintiff's Second Amended Motion does not meet the directives of District Judge Batchelder's Memorandum. Any class member who is not employed by

Dallas Warehouse will have a Certificate of Coverage negotiated by his own employer (the COSE member group), COSE and BCBSO. Plaintiff has failed "to create a lesser class of subscribers who have coverage under a contract negotiated by the same parties. Memorandum at 14. (emphasis added). For these reasons, plaintiff's class again fails the typicality requirement.

4. Numerosity

Rule 23(a)(1) requires plaintiff to show that the class is so numerous that joinder of all members is impracticable. In his Amended Motion to Certify a Class, plaintiff indicated that at least 3,672 BCBSO subscribers undergo Cardiac Rehab each year. Memorandum at 7. In her memorandum, District Judge Batchelder asserted that this number obviously meets the numerosity requirement. Id.

The number of persons in the proposed class decreased severely once the proposed class was limited in the Second Amended Motion to only BCBSO subscribers whose contracts were issued through COSE. Plaintiff estimates that there is an 'absolute minimum' of 41 persons in the new proposed class, and speculates that the class may be "larger than 100, and could easily be as large as 140 and more." Second Amended Motion at 10.

Assuming, arguendo, that plaintiff's proposed class does satisfy the typicality requirement (although we have previously held that it does not, pp. 7-9), it still fails to satisfy numerosity. All the members of the proposed class would by definition be associated with COSE, a division of the Greater Cleveland Growth Association. Consequently, it is logical to assume that all members of the class would be found in or around the Greater Cleveland area. Thus, joinder of the individual plaintiffs, whether they number 41 or 141, would not be so burdensome as to be "impracticable".

5. Application of Rule 23(b)

District Judge Batchelder hold that even if the typicality requirement were met, the class proposed in plaintiffs Amended Motion would not survive analysis under Rule 23(b). Memorandum at 10. Plaintiff's proposed class would not meet the requirements of 23(b)(1)(A) or 23(b)(1)(B) "because BCBSO would not be subject to inconsistent standards of conduct if individual suits were brought . . . nor are subscribers' claims at risk because of a limited BCBSO fund." Id. Plaintiff has not presented any new facts in his Second Amended Motion to show that the limitation of the class to only BCBSO subscribers whose contracts were

obtained through COSE would change this analysis. Thus, plaintiff's class will not meet the requirements of Rule 23(b)(1)(A) or (B) under the,law of this case.

District Judge Batchelder hold that plaintiff's proposed class of all BCBSO subscribers also failed to meet 23(b)(2), for plaintiff did not prove that BCBSO acted or refused to act on grounds generally applicable to the entire class of BCBSO subscribers.

> [Defendant's] grounds for denying the claims revolve around the specific negotiations between BCBSO and each particular group. Therefore, defendant's actions are not on grounds generally applicable to all class members; they are on grounds specific to each group bargaining process with BCBSO.

Memorandum at 11. Even though plaintiff has restricted the class to COSE members, <u>each COSE member group</u> entered into separate and distinct communications and/or negotiations with BCBSO prior to purchasing an insurance package. Brief in Opp. at 7-9. Thus, it cannot be said that defendant's actions are on grounds generally applicable to the entire class of COSE members. Instead, defendant's actions are on grounds applicable to each COSE member group, or in plaintiff's

case, Dallas Warehouse. Thus, plaintiff's class again fails to satisfy the requirements of Rule 23(b)(2).

Finally, District Judge Batchelder held that plaintiff's proposed class would fail to meet the 'predominacy of common questions' requirement of 23(b)(3). Some common questions are involved in the, class including all BCBSO subscribers. To rule, however, on the ambiguous terms of plaintiff's insurance coverage, the Court must examine BCBSO's negotiations with plaintiff's insurance group. Therefore,

> It is impossible to say that the common questions predominate when the negotiations of each individual group must be explored in order to resolve the meaning of the ambiguous language. This Court cannot say that in this case the common questions of law and fact predominate over questions affecting only individual members. Neither can this Court say that the class action is the superior method for resolving such fact-specific inquiries as individual negotiations.

Memorandum at 11-13.

Plaintiff's class redefinition will not change this analysis. Even with the smaller class proposed in the Second Amended Motion, this court must still make fact-

specific inquiries into the individual negotiations Dallas Warehouse and other COSE member groups had with BCBSO. Thus, Plaintiff's newest class proposal does not fulfill the requirements of Rule 23(b)(3).

Accordingly, for the foregoing reasons, plaintiff's Second Amended Motion for Class Certification (Doc. #82) is DENIED.

IT IS SO ORDERED.

/s/ Paul R. Matia
UNITED STATES DISTRICT JUDGE

APPENDIX E

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

MEMORANDUM OF OPINION AND ORDER
[RE: GRANTING DEFENDANT'S MOTION TO DISMISS]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
	)	Case No. 1:90 CV 1483
vs.	)	
	)	JUDGE PAUL R. MATIA
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	

MEMORANDUM OF OPINION AND ORDER RE:
GRANTING DEFENDANT'S MOTION TO DISMISS

This action is before the Court upon defendant, Blue Cross & Blue Shield Mutual of Ohio's motion to dismiss Counts III, VI, VIII, and IX of the complaint with prejudice (Doc. #100). The Court has reviewed the memorandum in support and plaintiff's memorandum in opposition (Doc. #109). For the reasons that follow, the Court will grant the motion.[1]

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[1]The within matter came on for a final pretrial conference on November 30, 1993, at which time the Court

Defendant, Blue Cross & Blue Shield Mutual of Ohio ("Blue Cross") moves the Court for an order dismissing Counts III, VI, VIII, and IX of the complaint. Count 111 is for breach of an insurance contracts). Plaintiff admits that "he does not individually have a claim for breach of insurance contract under state law." Memorandum in opposition at 2. Counts VI and IX allege negligence per se (a derivative tort claim) and violations of Ohio Rev. Code Ann. § 3901.38, Ohio's prompt payment of health care benefits statute. Count VIII is for breach of duty to act in good faith.

The main argument of Blue Cross is that plaintiffs claims are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seg., which expressly preempts state law causes of action relating to employee benefit plans. Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides in pertinent part:

> . . . the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title...

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announced its decision to grant the within motion.

The Court holds that Counts III, VI, VIII, and IX of the complaint are an attempt by plaintiff to recover benefits under his Insurance Contract with Blue Cross. As a result, these state law claims will be dismissed because they are preempted by ERISA. Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1276 (6th Cir. 1991), cert. dismissed, --- U.S. ---, 113 S. Ct. 2 (1992), referring to Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987).

Blue Cross also contends that Count IX would not be saved from preemption by section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), commonly referred to as the "saving clause." The Court finds that Ohio Rev. Code Ann. § 3901.38 does not fall within the saving clause and is preempted by ERISA for the reasons contained in the memorandum in support at pages 8 through 13. See Taylor v. Blue Cross & Blue Shield of New York, 684 F. Supp. 1352 (E. D. La. 1988).[2] Further, the Court finds that Count VIII is not "saved" from the effects of the preemption clause by the saving clause as asserted by plaintiff at pages 2 through 4 of the memorandum in opposition.

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[2]Due to this holding of the Court, the Court will not address the alternative argument that Count IX fails for the reason that the Ohio prompt payment statute does not create a private cause of action in favor of plaintiff.

Blue Cross requests that plaintiff's prayer for relief in the form of punitive damages be dismissed. Plaintiff is limited under ERISA to recovering only contractual damages. Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (section 409 (a) of ERISA, 29 U.S.C. § 1109(a) , does not permit recovery of extra-contractual damages by a beneficiary of a plan); Varhola v. Doe, 820 F.2d 809, 817 (6th Cir. 1987) (punitive damages are not recoverable under section 502 (a) (3) of ERISA, 29 U.S.C. § 1132(a) (3)); Davis v. Kentucky Finance Cos. Retirement Plan, 887 F.2d 689, 696-7 (6th Cir. 1989), cert. denied, 495 U.S. 905 (1990). Accordingly,

Defendant, Blue Cross & Blue Shield Mutual of Ohio's motion to dismiss Counts III, VI, VIII, and IX of the complaint with prejudice (Doc. 1100) is GRANTED.

IT IS SO ORDERED.

Paul R. Matia
UNITED STATES DISTRICT JUDGE

APPENDIX F

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

MEMORANDUM OF OPINION AND ORDER
[RE: GRANTING DEFENDANT'S MOTION
FOR SUMMARY JUDGMENT]



IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
	)	Case No. 1:90 CV 1483
vs.	)	
	)	JUDGE PAUL R. MATIA
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	

MEMORANDUM OF OPINION AND ORDER RE: GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT[1]

This action is before the Court upon cross-motions for summary judgment (Doc.s #97 and 101). The Court has considered the memoranda in support, plaintiff's reply/memorandum in opposition (Doc. #108), counsel for

[1]The within matter came on for a final pretrial conference on November 30, 1993. The case was set for trial on December 13, 1993, but was subsequently reset for December 21, 1993. Prior to December 21, 1993, the Court announced its decision to grant defendant's motion.

plaintiffs letter dated December 7, 1993 and defense counsel's letter dated December 10, 1993. The Court has also considered the joint stipulation of facts (Doc. #114)[2] and the statement of uncontested fact that could have been stipulated (Doc. #113).[3]

The stipulated facts are as follows:

1. Plaintiff obtained health care benefits by virtue of Blue Cross Certificate of Insurance, Policy No. 285-66-6639, COSE Group No. 68116-B (the "Insurance Contract").

2. Plaintiff's Insurance Contract was obtained

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[2]The scheduling order issued on March 19, 1993 (Doc. #77) states in pertinent part:

> 4. Lead counsel of record shall confer with one another in person in order to prepare written stipulations as to all uncontested facts to be presented by the cross-motions for summary judgment. Said stipulations shall be filed with the Court on or before August 16, 1993.

The joint stipulation of facts was filed on December 3, 1993.

[3]Plaintiff's Motion to Strike (Doc. #115) was denied by marginal entry.

through his employment at Dallas Shoe Warehouse and is an "employee benefit plan" as that term is used by ERISA.

3. Exhibit A is a true and accurate copy of plaintiff's High Level Certificate, which is that portion of plaintiff's Insurance Contract which sets forth the benefits provided to plaintiff under the Insurance Contract.

4. Plaintiff obtained his Insurance Contract by virtue of Dallas' membership in the Council of Small Enterprises ("COSE"), a division of the Greater Cleveland Growth Association.

5. In the spring of 1989, employees of Dallas met with employees of Blue Cross to discuss Dallas' purchase of health insurance benefits.

6. At no time during the discussions between Dallas and Blue Cross did Blue Cross state whether Phase II Cardiac Rehabilitation ("Cardiac Rehab") was, or was not, a Covered Service that could be added to the Contract of Insurance.

7. During those discussions no one from Dallas asked Blue Cross whether Cardiac Rehab was a Covered service under the Contract of Insurance purchased by Dallas.

8. There was never any communication between a representative of Dallas and a representative of Blue Cross regarding Cardiac Rehab services prior to plaintiff's undergoing Cardiac Rehab services.

9. Plaintiff's Insurance Contract does not specifically exclude the term "Phase II Cardiac Rehabilitation."

10. Plaintiff's Insurance Contract does not specifically include the term "Phase II Cardiac Rehabilitation."

11. Plaintiffs Insurance Contract does include a heading entitled "Therapy Services" and specifically included under that heading is the subcategory "Treatment by Physical Means."

12. Plaintiff's Insurance Contract defines "Therapy Services" as "[t]he services and supplies which are defined in the benefits section and are used to promote recovery from illness or injury".

13. Under the Benefits section of plaintiff's High Level Certificate the following subcategories of Therapy Services are listed: **Radiation Therapy, Chemotherapy, Dialysis Treatments, Treatment by Physical Means,**

Respiratory and Pulmonary Therapy, and Inpatient Speech and Occupational Therapy.

14. Treatment by Physical Means is described in plaintiff's High Level Certificate as follows:

> The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical or neurophysiological principles and devices.

15. On May 22, 1989,[4] plaintiff was admitted to Mt. Sinai Medical Center for a procedure known as percutaneous transluminal coronary angioplasty ("angioplasty"), after which plaintiff was prescribed to undergo Cardiac Rehab Therapy. The term "percutaneous transluminal coronary angioplasty" does not appear in the language of plaintiff's Insurance Contract.

16. Following July 24, 1989, plaintiff participated

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[4]The Joint Stipulation of Facts incorrectly states "March."

in thirty-three (33) Cardiac Rehab sessions over a five-month period.

17. Blue Cross never considered whether plaintiff's Cardiac Rehab was medically necessary because Blue Cross did not consider plaintiff's Cardiac Rehab to be a Covered service.

18. Blue Cross did provide reimbursement for plaintiff's angioplasty.

19. On April 27, 1990, Blue Cross informed plaintiff that Blue Cross would not provide reimbursement for the. Cardiac Rehab Therapy because Dallas "did not select a contract to provide additional benefits for cardiac rehabilitation."

A class action complaint for preliminary and permanent injunction and other relief and a motion for preliminary injunction were filed on August 17, 1990. Plaintiff alleged that defendants, Blue Cross & Blue Shield Mutual of Ohio, et al. ("Blue Cross") wrongfully denied his request for payment in the amount of $2,145.00 for Cardiac Rehab. Count I is for failure on the part of Blue Cross to provide benefits due under an employee welfare benefit plan. Count II alleges breach of fiduciary duty under 29

U.S.C. § 1132.[5]

Plaintiff now moves the Court for partial summary judgment as to Count I -- the basic contract issue. The issue is whether plaintiff's Cardiac Rehab is a Covered Service requiring that Blue Cross reimburse plaintiff under the Insurance Contract. Blue Cross moves the Court for summary judgment as to Counts I and II.

I.

> Summary judgment is appropriately granted when . . . the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law...

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[5]Plaintiff's motion for order of voluntary dismissal without prejudice of Counts IV, V and VII (Doc. #81) was granted by marginal entry on June 10, 1993. On March 24, 1994, the Court issued a Memorandum of Opinion and Order (Doc. #117) granting defendant's motion to dismiss Counts III, VI, VIII, and IX of the complaint with prejudice.

Fed. R. Civ. P. 56(c). See also Meade v. Pension Appeals and Review Comm., 966 F.2d 190, 192-93 (6th Cir. 1992).

The moving party, however, is not required to file affidavits or other similar materials negating a claim on which its opponent bears the burden of proof, so long as the movant relies upon the absence of the essential element in the pleadings, depositions, answers to interrogatories, and admissions on file. Celotex Corp. v. Catrett, 477 U.S. 3170 322 (1986). The moving party must "show that the non-moving party has failed to establish an essential element of his case upon which he would bear the ultimate burden of proof at trial." Guarino v. Brookfield Township Trustees, 980 F.2d 399, 403 (6th Cir. 1992). In reviewing the motion for summary judgment, the Court must view the evidence in the light most favorable to the non-moving party when deciding whether a genuine issue of material fact exists. Matushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587-88 (1986); Adickes v. S.H. Kress & Co., 398 U.S. 144 (1970); White v. Turfway Park Racing Assn., Inc., 909 F.2d 941, 943-44 (6th Cir. 1990).

The United States Supreme Court, in deciding Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986), stated that in order for a motion for summary judgment to be granted, there must be no genuine issue of material fact. Id. at 248. A fact is "material" only if its resolution will

affect the outcome of the lawsuit. In determining whether a factual issue is "genuine" the Court must decide whether the evidence is such that reasonable jurors could find that the non-moving party is entitled to a verdict. Id. The existence of a mere scintilla of evidence in support of the non-moving party's position ordinarily will not be sufficient to defeat. a motion for summary judgment. Id. at 252.

II.

Plaintiff's claim involves an interpretation of a particular "Covered Service" contained in his Insurance Contract. The Certificate of Insurance ("Certificate") states as follows:

> **Therapy Services**
>
> Services or supplies used to promote recovery from an illness or injury include:
>
> * * * *
>
> Treatment by Physical Means -- The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical or neurophysiological principles and devices.

> The number of visits which your coverage provides is specified in the Schedule of Benefits. We may approve additional treatments, however, if your Physician or Professional Other Provider explains in writing the reason for more treatments and we determine that they are Medically Necessary.
>
> * * * *

Id. at 9-10.

The Certificate states further:

> **Schedule of Benefits**
>
> * * * *
>
> **Treatment by Physical Means**
>
> 10 treatments per Benefit Period are covered.
>
> * * * *

Plaintiff argues initially that the plain, clear and unambiguous language of the Certificate provides coverage for Cardiac Rehab. Memorandum in Support at 12-15. However, this Court has previously found that the "Treatment by Physical Means" language is ambiguous. On December 9, 1991, District Judge Alice M. Batchelder issued a seventeen-page Memorandum of Decision

("Memorandum") (Doc. #56) in the case at bar.[6] It provides in pertinent part:

> **6. Conclusion**
>
> ...this Court grants plaintiff leave to amend his motion to certify class to set out a lesser class, such as (a) class of COSE subscribers, in which this Court would need only consider the negotiations between BCBSO and the group that negotiated plaintiff's Certificate of Coverage to rule on the **ambiguous "Treatment by Physical Means" language**.
>
> Id. at 14. (Emphasis added.)

See also Memorandum of Opinion and Order issued on June 14, 1993 (Doc. #90) at 2. The law of the case is that the "Treatment by Physical Means" language is ambiguous!

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[6]The within matter was originally assigned to District Judge Batchelder. Judge Batchelder was appointed United States Circuit Court Judge for the Sixth Circuit on June 12, 1991, and entered on duty January 4, 1992. On December 20, 1991, the case was transferred to the undersigned.

Plaintiff argues further that, assuming arguendo that the Certificate is ambiguous, summary judgment in plaintiff's favor is still appropriate because it was the intention of the parties to provide coverage for Cardiac Rehab. However, for the reasons that have been articulated at pages 8-14 of the memorandum of the points and authorities on which defendant relies in support of its motion, plaintiff has presented no evidence that the parties intended Cardiac Rehab to be covered.

It is undisputed that Cardiac Rehab is not a specifically listed Covered Service within the Certificate. Blue Cross does not argue that Cardiac Rehab falls within one of the specific exclusions contained in the Certificate. Rather, it asserts that Cardiac Rehab is only a covered benefit when it has been specifically negotiated by the parties to be included in the Certificate.

The Court finds that Cardiac Rehab is not a "Therapy Service" which fits the description of "Treatment by Physical Means" in plaintiff's certificate in the case at bar. The statement of fact that could have been stipulated to supports this finding.[7] This fact was previously

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[7]The statement of uncontested fact that could have been stipulated (Doc. #113) is as follows:

Blue Cross does issue High Level Certificates which

recognized by the Court. See Memorandum at 13. Therefore, the Court holds that plaintiff's Cardiac Rehab is not a Covered Service requiring that Blue Cross reimburse plaintiff under the Insurance Contract.

III.

For the foregoing reasons, defendant's motion for summary judgment (Doc. #101) is GRANTED and plaintiff's motion for partial summary judgment (Doc. #97) is DENIED upon the grounds that there is no genuine issue as to any material fact and Blue Cross is entitled to a judgment as a matter of law on Counts I and II of the complaint. A final and appealable judgment will be entered in favor of defendant.

The Clerk of Court shall issue a copy of this Memorandum of Opinion and Order to Steven S. Kaufman, Esq., Gail E. Sindell, Esq. and Thomas L. Feher, Esq., Kaufman & Cumberland Co., L.P.A., 1404 East Ninth Street - #300, Cleveland, Ohio 44114-1779; and George F. Karch, Esq., and Patrick F. Haggerty, Esq., Thompson,

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specifically include the subcategory of Therapy Services entitled 'Cardiac Rehabilitative Services.'

Hine and Flory, 1100 National City Bank Bldg., Cleveland, Ohio 44114.

IT IS SO ORDERED.

/s/ Paul R. Matia
UNITED STATES DISTRICT JUDGE

APPENDIX G

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PETITION FOR REHEARING WITH
SUGGESTION FOR REHEARING *EN BANC*

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

CHAIM SCHACHNER, Plaintiff, vs. BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	))) COURT OF APPEALS) CASE NO. 94-4217)) Appeal From Northern District) of Ohio) Case No. 1:90 CV 1483)

PETITION FOR HEARING
(SUGGESTION OF *EN BANC* HEARING)

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Attorneys for Defendants-Appellees

I express a belief, based on a reasoned and studied professional judgment, that the panel decision is contrary to the following decisions of the Supreme Court of the United States and the United States Court of Appeals for the Sixth Circuit and that consideration by the full Court is necessary to secure arid maintain uniformity of decisions: Singleton v. Wulff, 428 U.S. 106, 120 (1975); Meade v. Pension Appeals And Review Committee, 966 F.2d 190 (6th Cir. 1992) and that consideration of this appeal will aid in the resolution of the confusion created by the treatment of Local 783, Allied Industrial Workers v. General Electric Co., 471 F.2d 751, (6th Cir.), cert. denied, 414 U.S. 822, 94 S.Ct. 120, 38 L.Ed.2d 55 (1973) in United Automobile Workers v. Yard-Man, Inc., 716 F.2d 1476 (6th Cir. 1983) cert. denied, 465 U.S. 1007, 104 S.Ct. 1002, 79 L.Ed.2d 234 (1984).

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INTRODUCTION

This Court decided a threshold issue, which will affect the many issues being remanded, without affording the parties an opportunity to argue or brief the issue and even though the Appellee had requested the opportunity to brief the issue if the lower court determined it necessary. In so doing, this Court added to, or recreated, the confusion in this Circuit over when it is proper to resort to extrinsic evidence to interpret a contract. The ruling also violates the directives of the Supreme Court of the United States and the Sixth Circuit court of Appeals instructing appellate courts not to decide issues which were never presented to them or to the lower court.

Based upon a misapprehension of the procedural posture of this case and a misapplication of this Circuit's decisions regarding the resort to extrinsic evidence to interpret a contract, this Court determined that the definition of the contested phrase "Treatment by Physical Means" was not ambiguous. This ruling deprived Appellee of the opportunity to present an argument, based upon the language of the certificate, as to whether the words "Treatment" or "Physical" or "Physical Means" or other words of the phrase's textual definition, are ambiguous. Having been deprived of this opportunity, Appellee is then instructed to offer its position on the numerous remanded issues which all flow from the determination improperly

made.

SUMMARY OF ARGUMENT

This case involves Plaintiff/Appellant Chaim Schachner's ("Schachner") claim that the cardiac rehabilitation program he participated in is a covered service under his Certificate of Insurance with Defendant/Appellee Blue Cross and Blue Shield of Ohio ("Blue Cross"). Schachner claims the program is a benefit under the covered service entitled "Treatment by Physical Means." The parties and the Court agree that the first issue to be addressed in deciding Schachner's claim is whether the meaning of the term Treatment by Physical Means is clear or whether the determination of its meaning requires the resort to extrinsic evidence.

The first district court judge (Batchelder J.) determined the clause was ambiguous, describing it as "unintelligible." (R.56 at p. 12). As a result, the district court considered extrinsic evidence in denying Schachner's attempts to certify a class and in granting Blue Cross' Motion for Summary Judgment.

On appeal, this Court disagreed with Judge Batchelder's initial determination of ambiguity, declaring that the district court's finding of ambiguity, made in the context of class certification briefing, was made *sua sponte,* without being "briefed or argued" by either party. (March

8, 1996 Opinion at p. 8, attached as Appendix A). This Court then determined that the second district court judge (Matia J.) erroneously granted summary judgment in favor of Blue Cross based on "extrinsic evidence without making an informed determination that 'Treatment by Physical means' is, in fact, ambiguous." (Id. at p. 8)

Despite this finding, this Court's order of remand did not include instructions to Judge Matia to hear argument and consider the issue of whether the language is ambiguous. Instead, after determining that the threshold issue had never been briefed, this Court then examined Blue Cross' presentation of extrinsic evidence -- offered to interpret the ambiguity found by the district court -- and found the presentation to be an improper "maneuver" aimed at creating an ambiguity. Based upon this misapprehension, this Court found that Blue Cross had failed to prove ambiguity without resorting to extrinsic evidence and declared the language was not ambiguous, thus deciding an issue which had never been properly addressed either before the district court or this Court.

The prejudice of this ruling is even more manifest in light of Blue Cross' request to Judge Matia to brief the substantive issues (including the question of whether or not the language was ambiguous) if he deemed it necessary.[1]

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[1]This request was made while newly appointed Judge Matia was considering whether to reopen a previous ruling

Judge Matia never deemed it necessary and thus, the issue was never properly presented. As a result, Blue Cross never "briefed or argued" the threshold issue before either Judge Batchelder or Judge Matia because Judge Batchelder decided the issue *sua sponte* and Judge Matia determined not to take argument on the issue. This Court's decision, which will have far reaching implications on remand, violates the basic tenent of appellate procedure of allowing the parties an opportunity to present their arguments of fact and law to the district court before an appellate ruling is made.

Moreover, it adds greatly to the very confusion this Court was trying to resolve. This Court was attempting to refute what "[s]ome have argued, based primarily on our opinion in International Union, United Automobile Workers v. Yard-Man, 716 F.2d 1476 (6th. Cir. 1983), cert. denied 465 U.S. 1007 (1984), [that] we have broadened our rule on the consideration of parol evidence since our opinion in Local 783, Allied Industrial Workers v. General Electric, 471 F.2d 751 (6th Cir.) cert. denied, 414 U.S. 822 (1973). (Appendix A at p. 6).[2] However, by analyzing Blue

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of then District Court Judge Batchelder. Judge Matia explicitly acknowledged the request. (R.80 at p. 5, ln. 3).

[2]In Yard-Man, the court declared that "[t]he intended meaning of even the most explicit language can, of course, only be understood in light of the context which gave rise

Cross' extrinsic evidence (offered to interpret a **declared ambiguity**) in the context of whether Blue Cross had demonstrated the existence of the ambiguity, this Court repeated the same mistake the Serrano plaintiffs made and blurred the distinction it was trying to draw.

Since the matter is being remanded for extensive proceedings regarding whether Schachner's claim falls within the contract language, whether class certification is appropriate and whether certain state law claims survive, it is appropriate for this Court to include a remand on the threshold question of whether or not the subject language is ambiguous.

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to its inclusion." Yard-Man, 716 F.2d at 1479. Subsequently, the litigants in Serrano v. Jones & Laughlin Steel Co., 790 F.2d 1279 (6th Cir. 1986), relying on this Yard-Man language, attempted to prove the existence of an ambiguity by resort to extrinsic evidence. The Serrano court explained that the Yard-Man court's resort to extrinsic evidence came only after the agreement was first found to be ambiguous.

LAW AND ARGUMENT

I. THE PARTIES NEVER BRIEFED THE ISSUE OF WHETHER OR NOT THE SUBJECT LANGUAGE WAS AMBIGUOUS

A. Judge Batchelder's Finding Of Ambiguity Was *Sua Sponte*

This Court found that the parties never addressed the threshold issue of whether or not the subject language was ambiguous:

> In its 1991 memorandum opinion, the court determined, for the purposes of denying a motion to certify a class, that "Treatment by Physical Means" is an ambiguous phrase. There is no indication in the record before us that, at that point in the litigation, the parties had either briefed or argued the ambiguity issue. . . .

After finding that the district court's decision was made *sua sponte,* this Court stated:

> Thus, the later judge should not have granted summary judgment based on [Blue Cross] extrinsic evidence without making an informed determination that "Treatment by Physical Means" is, in fact, ambiguous. (Appendix A at p. 8).

Apparently, this Court believes that the lower court did, at some later time, hear and consider each parties' attempt to offer a plausible interpretation of the disputed clause from the text of the document. It did not.

B. Judge Matia's Analysis Of The Law Of The Case Did Not involve An Examination Of Whether The Language Was Ambiguous

At page 8 of the March 8, 1996 Opinion, this Court found as follows:

> Whether or not the prior judge erred in making that *sua sponte* determination in the 1991 memorandum opinion, the later judge erred in relying on the determination as "the law of the case" in 1994.

(Appendix A at p. 8). In so finding, this Court completely misapprehended the procedural history of this case.

This Court's opinion implies that the district court was presented with arguments and briefs concerning whether Treatment by Physical Means was clear or ambiguous on its face and finds that the district court erred in not revisiting this issue when the parties briefed it. However, an examination of the record demonstrates that the trial court did not review the issue and indeed the issue was not briefed for the court.[3]

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[3]This Court's confusion is understandable in light of the multitude of the motions and brief which were filed within

When Schachner filed his Second Amended Complaint (R.60), Blue Cross filed a Motion to Strike (R.63) claiming that the class proposed in the Second Amended Complaint went well beyond that described in Judge Batchelder's December 6, 1991 Memorandum of Decision. In response, Schachner moved for Leave to File a Second Amended Complaint and Motion for Reconsideration of the December 6, 1991 Order (R.67). The basis for Schachner's leave to file a new complaint exceeding Judge Batchelder's directive was his claim that new evidence existed which would enable Judge Matia to reopen Judge Batchelder's earlier Order. Blue Cross opposed this request claiming that the claimed new evidence had been before Judge Batchelder at the time she made her decision.

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60 days after Judge Matia ordered his first status hearing on this matter after being reassigned Judge Batchelder's entire civil docket. The court received the following documents: Schachner's Second Amended Class Action Complaint, (R.60); Schachner's Memorandum in Support of and Relating to Plaintiff's Second Amended Complaint, (1.1.61); Blue Cross' Motion to Strike Second Amended Complaint, (Ft.63); Schachner's Motion for Leave to File Second Amended Complaint with Memorandum in Support, (R. 65, 66) ; Schachner's Motion for Reconsideration of December 6, 1991 Order, (R. 67) ; Blue Cross I Response to Motion for Reconsideration and to Motion for Leave to File Second Amended Complaint, (R.70) Additionally, the court was confronted with a number of discovery motions.

Given Blue Cross' demonstration that the claimed now evidence had actually been presented to Judge Batchelder by Schachner himself, Blue Cross did not address the numerous issues contained in the various Schachner complaints, memoranda and motions. However, Blue Cross specifically noted that should the court believe it is necessary for the substantive issues, including ambiguity, to be briefed, then Blue Cross specifically requested the right to present arguments on that issue:

> In view of these reasons, Blue Cross submits that it would serve no good purpose now to respond in detail on the merits to all of the erroneous contentions and conclusions of Schachner in his 30-page brief seeking to overturn Judge Batchelder's Order. However, in the event that this court determines to hear on the merits all of the contentions now advanced in Schachner's motion to reconsider the class action determination by Judge Batchelder, Cross requests leave to be able to specifically respond to those erroneous contentions. (Emphasis added).

(Blue Cross' May 11, 1992 Memorandum in Response to Plaintiff's Motion for Leave to file Second Amended Complaint and Motion for Reconsideration of December 6, 1991 Order, R.70 at p. 4, ln. 1). When the court issued its opinion, it specifically noted that Blue Cross had requested the right to brief the issue:

> Blue Cross' requests leave to file a memorandum in opposition to the merits of plaintiff's memorandum on the points and authorities on which he relies in support of his motion for reconsideration, if the court determines that it will consider plaintiff's contentions on the merits.

(R.77 at p.5, ln. 3). However, the district court determined not to hear the issues on the merits and therefore Blue Cross' request for leave was not granted. Accordingly, Blue Cross never presented argument on the issue of whether or not the contract language was ambiguous on its face.

C. Schachner Never offered An Interpretation Of Treatment By Physical Means Based On The Face Of The Certificate

This Court erroneously determined that only Schachner had drawn a plausible interpretation of "Treatment by Physical Means" from the text of the certificate. This finding is incorrect. As demonstrated above, the issue was never presented to the district court and Schachner's statements to this Court relied upon extrinsic evidence.

The parties never mentioned the issue of ambiguity until Schachner's April 20, 1992 Memorandum in Support of Plaintiff's Motion for Leave to File Second Amended Complaint, etc. (R.66), when Schachner explained "This is

the first time Plaintiff has presented any evidence, discussion or analysis regarding this issue." Id. at p. 24. (R.66 at p. 24). Moreover, an examination of Schachner's arguments regarding ambiguity reveals that such arguments always involved a reference to extrinsic evidence.[4] Thus, not even Schachner offered the district court an interpretation of the language of the certificate without resort to extrinsic evidence.

For example, Schachner's April 20, 1992 brief goes on to "prove" the absence of ambiguity by referring to an internal memorandum of Blue Cross ("Goebel Memo") and the affidavit of Schachner's doctor, r)r. Michael Rocco, ("Rocco Affidavit"). Thus, Schachner's admitted first attempt to discuss the issue of ambiguity entailed a resort to extrinsic evidence.

Similarly, Schachner's August 16, 1993 Motion for Partial Summary Judgment once again referred to the

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[4]Schachner did continue to raise the issue of ambiguity, intermittently, even after the court's 1991 and 1993 orders. In essence, he ignored the district court's finding of ambiguity. Alternatively, Blue Cross did not address the issue of ambiguity because the court had said the matter was closed. If this court determines that only Schachner met his burden of offering an interpretation without resort to extrinsic evidence, such a finding would not only be erroneous, it would, in fact, reward Schachner for ignoring the court's Order and punish Blue Cross for acting in conformity with those Orders.

Goebel Memo, the Rocco Affidavit and Schachner's own deposition testimony as proof of the lack of ambiguity. Moreover, Schachner's analysis referred to the "average beneficiary's reading of the policy" -- which is set forth as an extrinsic tool of interpretation of an ambiguous clause in Taylor v. Continental Group, 933 F.2d 1227 (3d Cir. 1991). (R.97 at pp. 12-15). Thus, Schachner's attempt to prove the lack of ambiguity relied almost completely on extrinsic evidence. Id. at p. 1212-1215.[5]

Again, in Schachner's September 13, 1995 Reply/Brief in Opposition to Defendant's Motion for Summary Judgment, he refers to the Goebel Memo, the Rocco Affidavit and Blue Cross' course of conduct before stating:

> Both the medical literature and Blue Cross' own internal memoranda define cardiac rehabilitation in terms identical to those used by Blue Cross in defining Treatment By Physical Means.

Id. R.108 at p. 6, (emphasis as original).

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[5]Schachner's motion did state that "the plain and natural meaning of these words encompasses Phase II Cardiac Rehabilitation" (Id. at p. 12); however, there is no more than this bold statement. Furthermore, by the time Schachner made this statement, the district court had twice ruled that the
language was ambiguous.

Finally, in his brief before this Court, Schachner resorts to extrinsic evidence to interpret the meaning of Treatment by Physical Means. Under the heading "The Plain Meaning of the Plan Language" Schachner first merely states that the words of the definition are "common" and "clear" and then discusses "the uncontroverted evidence which demonstrates that "cardiac rehab fits exactly into the definition of Treatment by Physical Means." (Appellant's Brief at pp. 15-18).[6]

At no time has either Schachner or Blue Cross attempted to define the words "Treatment" or "Physical" or "Physical Means" that are contained in the certificate by reference only to the certificate. Briefing and analysis by both parties as to the many possible meanings of these words are essential before any determination can be made as to whether the language of the certificate is ambiguous by reference only to the words in the certificate.

II. THIS COURT'S RELIANCE ON SERRANO IS MISPLACED AND THE EXAMINATION OF THE EXTRINSIC EVIDENCE IS IN ERROR

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[6]Schachner's resort to extrinsic evidence to prove cardiac rehab (in the abstract) "fits" Treatment by Physical Means is a different analysis from the factual issue this Court has remanded viz., "whether Schachner's cardiac rehab sessions fit within the unambiguous definition of "Treatment by Physical Means". (Appendix A at p. 10).

At pages 8-10 of the March 8, 1996 Opinion, this Court reviews the extrinsic evidence offered by Blue Cross. It is clear from the Court's language that this Court erroneously believes that Blue Cross was offering this extrinsic evidence to prove the existence of an ambiguity. However, Blue Cross was not attempting to prove an ambiguity; it offered the evidence to interpret the language which the trial court had determined was ambiguous. Under these circumstances, the resort to extrinsic evidence is proper and necessary. Thus, when this Court states as follows:

> In *Serrano,* we rejected the plaintiff's attempt to rely on extrinsic evidence to create an ambiguity in an agreement which we found to be patently unambiguous. 790 F.2d at 1288-1289. We will not allow blue Cross to attempt the same maneuver here.

(Appendix A at p. 9), this Court is clearly misapprehending what Blue Cross was attempting to do with its resort to extrinsic evidence. Blue Cross **never intended the extrinsic evidence to prove the ambiguity,** rather it offered it to resolve the ambiguity, that the district court had found in its 1991 Opinion.

This Court's reliance on Serrano v. Jones & Laughlin Steel Co., 790 F.2d 1279 (6th Cir. 1986) demonstrates its confusion. In Serrano, the plaintiff attempted to prove an ambiguity by resort to extrinsic evidence, claiming the analysis was proper in light of

United Automobile Workers v. Yard-Man, Inc., 716 F.2d 1476, 1479 (6th Cir. 1983), cert. denied, 465 U.S. 1007, 104 S.Ct. 1002, 79 L.Ed.2d 234 (1984). The Serrano court used that opportunity to explain that Yard-Man did not change the rule stated in Local 783, Allied Industrial Workers v. General Electric Co., 471 F.2d 751, 757 (6th Cir.), cert. denied, 414 U.S. 822, 94 S.Ct. 12O, 38 L.Ed.2d 55 (1973). Serrano does not prohibit Blue Cross from making the presentation it did regarding extrinsic evidence - it supports what Blue Cross did.

By analyzing Blue Cross' "post-ambiguity" offer of extrinsic evidence to determine whether it demonstrates a contextual ambiguity, this Court has added to the confusion it was attempting to resolve. The remedy is a remand with clear instructions to the district court to hear arguments, limited to the face of the certificate, to determine whether the definition of Treatment by Physical Means is ambiguous.

III. THE EFFECT OF THIS COURT'S RULING ON THE ISSUE OF AMBIGUITY VIOLATES THE PROCEDURES SET FORTH IN SINGLETON AND MEADE AND DENIES BLUE CROSS AN OPPORTUNITY TO PRESENT ANY ARGUMENT ON WHETHER TREATMENT BY PHYSICAL MEANS IS AMBIGUOUS.

A. Every Party Must Be Afforded An opportunity To Be Heard.

It is axiomatic that each party to a lawsuit must have a full and fair opportunity to dispute the issue before the court. Although our court system's procedural scheme contemplates initial review by a trial court,[7] the primary concern is that both parties "have the opportunity to offer all the evidence they believe relevant to the issues" and that they not be surprised by a final decision on issues upon which they had no opportunity to present evidence. See Singleton v. Wulff, 428 U.S. 106, 120 (1975)(citing Hormel v. Helvering, 312 U.S. 552 (1941)). In addition to

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[7]As a general rule, issues not litigated in the trial court are generally riot appropriate for appellate consideration in the first instance. Taft Broadcasting Company, v. United States, 929 F.2d 240, 243 (6th Cir. 1991). In limited, exceptional circumstances, however, such as where proper resolution is beyond any doubt or where injustice might otherwise result, an appellate court may address an issue not litigated below. See United States v. Baker, 807 F.2d 1315 (6th Cir. 1986). Additionally, appellate courts, on a very few occasions, have addressed purely legal issues presented on appeal for the first time. See, e.g., Frederick Steel Co. v. C.I.R., 375 F.2d 351 (6th Cir. 1967) (statutory interpretation of tax code to determine tax matter). However, and more importantly, in these cases the issue ruled upon by the appellate court was always fully argued and addressed by both parties. Because Blue Cross has never argued ambiguity, that is not the case here.

evidence, each party must have the opportunity to present whatever legal arguments it may have in defense of its position. See Singleton, 428 U.S. at 120 (Court of Appeals incorrectly ruled on the merits of the case because petitioner, justifiably reserving his arguments until standing was first resolved, was never given an opportunity to be heard on the merits). When a court passes upon an issue without affording a party an opportunity to be heard, an injustice is more likely to be caused than avoided. Id. at 121. Thus, no decision should be rendered before both parties are afforded a full and fair opportunity to argue the issue that is being determined by the court.

The Sixth Circuit as well as other Circuits have followed this principle. See, eg., English v. Dyke, 23 F.3d 1086 (6th Cir. 1994)(appellate court refused to rule on the merits of defendant's qualified immunity defense because neither party had argued that issue); see also Jones v. Duncan, 840 F.2d 359 (6th Cir. 1988)(where the district court incorrectly dismissed plaintiff's unaddressed § 1985 claim, the reviewing court would not express an opinion on the merits because neither parties had addressed the issue); Williams v. City of St. Louis, 783 F.2d 114 (8th Cir. 1986)(at a minimum, the court must provide the party a meaningful opportunity to address the constitutionality of the statute since denial of an opportunity to make legal arguments is exactly what the summary judgment rule is intended to prevent); E.C. Ernst, Inc. v. General Motors

Corp., 537 F.2d 105 (5th Cir. 1976)(appellate court cannot render summary judgment for non-moving party where moving party has not been given a full and fair opportunity to dispute the facts alleged by his adversary).

The Sixth Circuit has clearly demonstrated its adherence to this rule in its decision in Meade v. Pension Appeals And Review Committee, 966 F.2d 190 (6th Cir. 1992). In Meade, the district court had applied the "arbitrary and capricious" standard of review to the defendant's decision to deny benefits under an ERISA plan without determining whether the plan gave the administrator discretionary authority to determine benefits. The appellant argued, and the appellate court agreed, that pursuant to Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989), the district court had to first review the ERISA plan to determine if it provided such discretionary authority. Meade, 966 F.2d at 195, 196. After acknowledging that Firestone applied as a matter of law to plaintiff's claim under the plan, the Meade Court remanded this matter to the district court for a determination to be made below first rather than deciding the issue itself.

This is the same tact this Court should have taken in the present case. This Court stated that the district court's sua sponte finding of ambiguity was uninformed because neither party had briefed or argued the issue. (Appendix A at p. 8). After recognizing the trial court's haste in rendering such an "uninformed" decision, this Court

inadvertently proceeded to make the same error. In order to preserve Blue Cross's right to present its argument on the issue of ambiguity, this Court, as it did in Meade, should remand the matter to the district court for a complete briefing by both parties.

CONCLUSION

For the foregoing reasons, Appellees respectfully request this Court to include within the remand additional instructions to determine whether "Treatment by Physical Means" is ambiguous, based on the parties' briefing of the language of the certificate.

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CERTIFICATE OF SERVICE

A copy of the foregoing Petition for Rehearing (Suggestion of En Banc Hearing) was served upon Steven S. Kaufman,, Esq., Gail E. Sindell, Esq., Thomas L. Feher, Esq. of Kaufman & Cumberland Co., attorneys for Plaintiff-Appellant, 1404 East Ninth Street, Third Floor, Cleveland, Ohio 44114, via regular U.S. mail, postage prepaid, this 22th day of March, 1996.

Stephen Richey

APPENDIX H

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ORDER DENYING PETITION FOR REHEARING

No. 94-4217

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

CHAIM SCHACHNER, individually and as representative of all similarly situated persons, *Plaintiff-Appellant,*	)	
v.	)	**ORDER**
BLUE CROSS AND BLUE SHIELD OF OHIO AND MUTUAL HEALTH SERVICES COMPANY, *Defendants-Appellees.*	)	

BEFORE: BROWN, WELLFORD, and MILBURN, Circuit Judges.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

Leonard Green, Clerk

APPENDIX I

STATUTE EXCERPTS

29 U.S.C. §1001, §1132, §1144

§1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded

preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

§1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

§1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

APPENDIX J

STATUTE EXCERPT

29 U.S.C. §185

§185. Suits by and against labor organizations

Venue, amount, and citizenship

(a) Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce as defined in this chapter, or between any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties, without respect to the amount in controversy or without regard to the citizenship of the parties.

Responsibility for acts of agent;
entity for purposes of suit;
enforcement of money judgments

(b) Any labor organization which represents employees in an industry affecting commerce as defined in this chapter and any employer whose activities affect commerce as defined in this chapter shall be bound by the acts of its agents. Any such labor organization may sue or be sued as an entity and in behalf of the employees whom it represents in the courts of the United States. Any money judgment against a labor organization in a district court of the United States shall be enforceable only against the organization as an entity and against its assets, and shall not be enforceable against any individual member or his assets.

Jurisdiction

(c) For the purposes of actions and proceedings by or against labor organizations in the district courts of the United States, district courts shall be deemed to have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in representing or acting for employee members.

Service of process

(d) The service of summons, subpena, or other legal process of any court of the United States upon an officer or agent of a labor organization, in his capacity as such, shall constitute service upon the labor organization.

Determination of question of agency

(e) For the purposes of this section, in determining whether any person is acting as an "agent" of another person so as to make such other person responsible for his acts, the question of whether the specific acts performed were actually authorized or subsequently ratified shall not be controlling.

June 23, 1947, c. 120, Title III, § 301, 61 Stat. 156.

APPENDIX K

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

AFFIDAVIT OF BENJAMIN MEOLA, R.N., M.S.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
vs.	)	Case No. 1:90 CV 1483
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	JUDGE PAUL MATIA

AFFIDAVIT OF BENJAMIN MEOLA, R.N., M.S.

NOW COMES the affiant, being duly sworn, deposes and states the following to be true and accurate to the best of his knowledge:

1. I am the Program Supervisor for the Cardiac Rehabilitation Program at The Mt. Sinai Medical Center.

2. I am a licensed registered nurse.

3. I received by Bachelor's degree from Kent State University.

4. I received a Masters degree from East Strousberg University.

5. I have been involved in the field of cardiac rehabilitation for 5 years.

6. Chaim Schachner began his Phase II outpatient cardiac rehabilitation program on July 24, 1989.

7. I have monitored the cardiac rehabilitation services rendered to Chaim Schachner and found them to be helpful for treating his medical condition and restoring function to his body.

8. These sessions consisted of supervised training and exercise to strengthen the cardiovascular system by improving the function of the circulatory system.

9. Mr. Schachner's medical condition significantly improved as a result of the cardiac rehabilitation sessions.

10. It is my opinion, based upon my education, training and work experience, that cardiac rehabilitation services are an effective method of restoring function to the heart and circulatory system, combating heart disease, and preventing future incidents of acute coronary distress.

11. Patients who are in need of cardiac rehabilitation services and who do not immediately enter into a program of supervised exercise and treatment are more likely to have a slower recovery, require additional medical treatment in the future,a nd will risk irreparable harm.

12. My department maintains records on dozens of patients with various types of insurance coverage.

13. To the best of my knowledge most insurance companies and other third party payers, including Prudential, Aetna, CIGNA, Travelers, many self insured employer groups, and Medicare, pay for outpatient cardiac rehabilitation services.

14. To the best of my knowledge Blue Cross & Blue Shield Mutual of Ohio does not pay for cardiac rehabilitation sessions, though I do not know why.

15. There have been many patients of the Mt. Sinai Medical Center, insureds of Blue Cross & Blue Shield Mutual of Ohio, who have not undergone cardiac rehabilitation services because Blue Cross & Blue Shield Mutual of Ohio has denied coverage for them.

16. Cardiac rehabilitation services restore function to the heart and circulatory system following disease or injury.

17. Cardiac rehabilitation services are helpful to restoring normal bodily function and reducing the likelihood of heart disease, angina, cardiac arrhythmia, coronary blockage and recurrent cardiac distress.

18. There is a plethora of medical research and literature which demonstrates the value of monitored exercise and cardiac rehabilitation services.

AFFIANT FURTHER SAYETH NAUGHT,

Benjamin Meola, R.N., M.S.

Sworn and subscribed in my presence this 17th day of August, 1990.

Ari H. Jaffee, Notary Public, State of Ohio

APPENDIX L

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

AFFIDAVIT OF DR. MICHAEL ROCCO
IN SUPPORT OF CLASS CERTIFICATION

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
vs.	)	Case No. 1:90 CV 1483
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	JUDGE BATCHELDER

AFFIDAVIT OF DR. MICHAEL ROCCO
IN SUPPORT OF CLASS CERTIFICATION

I, Michael B. Rocco, M.D., being first duly sworn, depose and state that:

1. I am of requisite age and capacity to give testimony.

2. I am the Director of Exercise and Cardiac Rehabilitation at the Mt. Sinai Heart Institute, as well as Assistant Professor of Medicine, Case Western Reserve University School of Medicine. An accurate copy of my curriculum vitae detaining my professional education and qualifications is attached hereto as Exhibit "1".

3. Formal Phase II Cardiac Rehabilitation therapy provides many benefits to those who receive it. The purpose of prescribing such treatment, to the people described in paragraph 6, is to:

a. improve the patient's physical working capacity and endurance;

b. allow the patient's body to compensate for his or her degenerative heart condition, and thus reduce the symptoms of said condition;

c. provide an earlier return to gainful employment;

d. improve the patient's coronary risk factor profile;

e. slow the progress of the patient's heart disease, which is the underlying cause of the patient's symptoms; and

f. decrease the patient's long term likelihood of mortality.

4. The recipients of formal Phase II Cardiac Rehabilitation therapy experience a return to, or

improvement in, physical comfort and quality of life (which they might not ever experience, or which might taken much longer to experience), and a reduction in the possibility of future cardiac episodes which may result in disability or death.

5. There are some number of patients which I have seen in my practice to whom I have prescribed formal Phase II Cardiac Rehabilitation therapy, but who have been unable to receive the treatment because their insurance would not pay for it. These persons will not have the benefit of earlier recovery from their disease condition and may face a statistically significant increase in risk mortality.

6. I feel that, under current standards of appropriate medical treatment, persons who have the following conditions, or who have undergone the following procedures, need formal Phase II monitored cardiac rehabilitation therapy in order to relieve pain, restore maximum function and to prevent future disability associated with heart disease:

a. myocardial infarction;

b. coronary artery bypass surgery for coronary artery disease;

c. stable angina pectoris;

d. documented myocardial ischemia by stress testing or electrocardiography in patients with coronary artery disease;

e. status post heart valve repair or replacement;

f. post coronary angioplasty;

g. post cardiac transplantation;

h. cardiomyopathy.

7. During the year 1990, the Mt.Sinai Heart Institute had approximately 250-300 new patients who participated informal Phase II Cardiac Rehabilitation.

8. All of the persons who underwent said therapy fit into one of the categories described in paragraph 6 above.

9. During 1990, approximately 18% of the Mt. Sinai Heart Institute patients who participated in the formal Phase II Cardiac Rehabilitation therapy are insured by Blue Cross Blue Shield Mutual of Ohio.

10. Coverage for these services is provided, on varying bases, by many other insurance companies, including other Blue Cross providers, and Medicare.

FURTHER AFFIANT SAYETH NAUGHT.

Michael B. Rocco, M.D.

SWORN TO AND SUBSCRIBED BEFORE ME, a Notary Public, this 29th day of April, 1991.

Tammy P. Gunya
Notary Public,
State of Ohio
My Commission Expires Sept. 17, 1995.
Recorded in Lake County.

APPENDIX M

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

EXCERPTS OF DEPOSITION OF
CHAIM SCHACHNER

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
	)	Case No. 1:90 CV 1483
vs.	)	
	)	JUDGE MANOS
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	

The deposition of CHAIM SCHACHNER, called by the Defendants for examination, pursuant to the Federal Rules of Civil Procedure, taken before Janice L. Andrews, a Registered Professional Reporter and Notary Public within and for the State of Ohio, taken at the offices of Thompson, Hine and Flory, 1100 National City Bank Building, Cleveland, Ohio, on Wednesday, the 9th day of October, 1991, commencing at 1:00 p.m., pursuant to notice.

A. I believe that I was -- once at the yearly checkup I went to see him, to see -- they added some machines or other things to the facility, but other than that, I don't believe I saw him.

Q. And the purpose of that visit was merely social, to say "Hello"?

A. Yes, and to see if something changed.

Q. And you weren't seeing if it changed because you were going to employ that machine, it was just out of curiosity?

A. Curious, yes.

Q. You earlier indicated --

A. Oh, excuse me.

Q. Yes.

A. I saw him, there was a party that they had a year later, or it was some kind of an anniversary, so they invited all the people that were in the course. So I saw Dr. Rocco and the others at Mt. Sinai.

Q. You earlier told me that Ben Meola told you that the cardiac rehabilitation charges would be paid by Blue Cross; is that right?

A. That most of the time it's covered, he said.

Q. Now, do you remember when he told you that?

A. I asked him before I started the program,

because I wanted to be sure that it is covered.

Q. Now, did he tell you that Blue Cross -- did he specifically say Blue Cross, or did he say insurance companies cover it, do you remember?

A. I don't remember.

Q. Did you do any independent investigation on your own?

A. Before?

Q. Yes, sir.

A. No.

Q. Did you talk with anyone else other than Ben Meola about whether it would be covered?

A. No.

Q. Did you look at your insurance policy, your certificate of insurance to see if it provided for coverage?

A. Only after my -- after I believe it was seven or eight sessions and it was thrown out, so then I looked.

Q. Who submitted the claims initially for the charges for the cardiac rehabilitation?

A. I believe Mt. Sinai.

Q. Do you know what the amount of the charge was?

A. I believe $65 per session.

Q. Do you know what was covered and what that...

* * * * *

APPENDIX N

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

STATEMENT OF UNCONTESTED FACT
THAT COULD HAVE BEEN STIPULATED,
WITH EXCERPTS OF EXHIBIT A:
SUBSCRIBER CERTIFICATE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
vs.	)	Case No. 1:90 CV 1483
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	JUDGE PAUL MATIA

STATEMENT OF UNCONTESTED FACT
THAT COULD HAVE BEEN STIPULATED

NOW COMES Defendant Blue Cross & Blue Shield Mutual of Ohio, by and through its undersigned counsel, pursuant to the March 18, 1992 Trial Order, and submits the following fact that is "uncontested and could have been stipulated" to by Plaintiff:

> Blue Cross does issue High Level Certificates which specifically include the subcategory of Therapy Services entitled "Cardiac Rehabilitative Services."

Attached as Exhibit A, at page 16, is an example of such a

High level Certificate. (This document was previously filed with the Court as Exhibit E to Blue Cross & Blue Shield Mutual of Ohio's Appendix filed in connection with its August 19, 1991 Brief in Opposition to Plaintiff's Amended Motion for Class Certification.)

This fact is uncontested and was specifically referred to by Judge Batchelder in the December 6, 1991 Memorandum of Decision at page 13.

Respectfully submitted,

George F. Karch (006154)
Patrick F. Haggerty (019703)

THOMPSON, HINE AND FLORY
1100 National City Bank Bldg.
Cleveland, OH 44114
(216) 566-5500

Attorneys for Defendants
Blue Cross and Blue Shield of Ohio

Blue Cross
Blue Shield
of Ohio



SUBSCRIBER CERTIFICATE

Your Health Care Benefits
and
How to Use Them

Health Care Certificate

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- cause serious and permanent damage to any of your bodily organs or parts.

Benefits are provided for the first treatment only.

Home and Office Visits

Medical Care and consultations to examine, diagnose and treat an injury, ailment, condition, disease, disorder or illness.

Well Baby Care

Eligible Dependents are covered for the first year following birth, regardless of Medical Necessity, for routine physical exams and immunizations.

Diagnostic Services

Diagnostic Services include:

- radiology, ultrasound and nuclear medicine,
- laboratory and pathology services,
- EKG, EEG and other electronic diagnostic medical procedures.

Dental Service

Dental services will be covered when due to an accidental injury to the jaws, sound natural teeth, mouth or face that occurred on or after your Effective Date. Such services must begin within one year from the date of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury.

Therapy Service

Services or supplies used to promote recovery from an illness or injury include:

Radiation Therapy - The treatment of disease by X-ray, radium or radioactive isotopes.

Chemotherapy - The treatment of malignant disease by chemical or biological agents.

Dialysis Treatments - The treatment by dialysis methods of an acute or chronic kidney ailment, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.

Treatment by Physical Means - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, hear or similar modalities, physical agents, biomechanical and neurophysiological principles and may include devices if we determine that they are Medically Necessary Braces and molds ar specifically excluded. This must be provided and billed by a Hospital or Freestanding Physical Therapy Facility in order to be considered a Covered Service.

After the tenth treatment, your Physician must certify that additional treatments are necessary and w must approve this pre-certification in order for coverage to continue.

Inpatient Physical Rehabilitation Services - Inpatient care received from a Rehabilitation Hospital Covered Services include inpatient Hospital services and Inpatient medical services.

Cardiac Rehabilitative Services - Benefits are provided for educational and exercise sessions for patients recovering from heart attacks or open heart surgery. This is a Covered Service only when provided in a structured Outpatient Hospital program.

Inpatient Respiratory, Hyperbaric and Pulmonary

Therapy - This must be provided and billed by a Hospital in order to be considered a Covered Service.

Inpatient Occupational Therapy - This must be provided and billed by a Hospital in order to be considered a Covered Service.

Inpatient Speech Therapy - This must be provided and billed by a Hospital in order to be considered a Covered Service.

Maternity Services

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, miscarriage, therapeutic and elective abortions are Covered Services.

APPENDIX O

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

JOINT STIPULATIONS OF FACT
WITH EXCERPTS OF EXHIBIT A:
BCBS HIGH LEVEL CERTIFICATE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

CHAIM SCHACHNER, Plaintiff,	)	
vs.	)	Case No. 1:90 CV 1483
BLUE CROSS AND BLUE SHIELD OF OHIO, et al. Defendants.	)	JUDGE PAUL MATIA

JOINT STIPULATION OF FACTS

Plaintiff Chaim Schachner ("Plaintiff") and Defendant Blue Cross & Blue Shield Mutual of Ohio ("Blue Cross"), by their attorneys hereby stipulate to the following facts in connection with this action:

1. Plaintiff obtained health care benefits by virtue of Blue Cross Certificate of Insurance, Policy No. 285-66-6639, COSE Group No. 68116-B (the "Insurance Contract").

2. Plaintiff's Insurance Contract was obtained through his employment at Dallas Warehouse and is an

"employee benefit plan" as that term is used by ERISA.

3. Exhibit A is a true and accurate copy of Plaintiff's High Level Certificate, which is that portion of Plaintiff's Insurance Contract which sets forth the benefits provided to Plaintiff under the Insurance Contract.

4. Plaintiff obtained his Insurance Contract by virtue of Dallas Warehouse's membership in the Council of Small Enterprises ("COSE"), a division of the Greater Cleveland Growth Association.

5. In the spring of 1989, employees of Dallas Warehouse met with employees of Blue Cross to discuss Dallas Warehouse's purchase of health insurance benefits.

6. At no time during the discussions between Dallas Warehouse and Blue Cross did Blue Cross state whether Phase II Cardiac Rehabilitation ("Cardiac Rehab") was, or was not, a Covered Service that could be added to the Contract of Insurance.

7. During those discussions no one from Dallas Warehouse asked Blue Cross whether Cardiac Rehab was a Covered Service under the Contract of Insurance purchased by Dallas Warehouse.

8. There was never any communication between a representative of Dallas Warehouse and a representative of Blue Cross regarding Cardiac Rehab services prior to Plaintiff's undergoing Cardiac Rehab services.

9. Plaintiff's Insurance Contract does not specifically exclude the term "Phase II Cardiac Rehabilitation."

10. Plaintiff's Insurance Contract does not specifically include the term "Phase II Cardiac Rehabilitation".

11. Plaintiff's Insurance Contract does include a heading entitled "Therapy Services" and specifically included under that heading is the subcategory "Treatment by Physical Means".

12. Plaintiff's Insurance Contract defines "Therapy Services" as **"[t]he services and supplies which are defined in the benefits section and are used to promote recovery from illness or injury"**.

13. Under the Benefits Section of Plaintiff's High Level Certificate the following subcategories of Therapy Services are listed: **Radiation Therapy, Chemotherapy, Dialysis Treatments, Treatment by Physical Means,**

Respiratory and Pulmonary Therapy, and Inpatient Speech and Occupational Therapy.

14. Treatment by Physical Means is described in Plaintiff's High level Certificate as follows:

> The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Such service includes physical treatments, hydro therapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical and neurophysiological principles and devices.

15. On March 22, 1989, Plaintiff was admitted to Mt. Sinai Medical Center for a procedure known as percutaneous transluminal coronary angioplasty ("angioplasty"), after which Plaintiff was prescribed to undergo Phase II Cardiac Rehabilitation Therapy. The term "percutaneous transluminai coronary angioplasty" does not appear in the language of Plaintiff's Insurance Contract.

16. Following July 24, 1989 Plaintiff participated in thirty-three Cardiac Rehab sessions over a five-month period.

17. Blue Cross never considered whether Plaintiff's cardiac rehab was medically necessary because Blue Cross did not consider Plaintiff's cardiac rehab to be a Covered Service.

18. Blue Cross did provide reimbursement for Plaintiff's angioplasty.

19. On April 27, 1990, Blue Cross informed Mr. Schachner that Blue Cross would not provide reimbursement for the cardiac rehab therapy because Dallas Warehouse "did not select a contract to provide additional benefits for cardiac rehabilitation".

Respectfully submitted,

George F. Karch (006154)
Patrick F. Haggerty (019703)

THOMPSON, HINE AND FLORY
1100 National City Bank Bldg.
Cleveland, OH 44114
(216) 566-5500

Attorneys for Defendants
Blue Cross and Blue Shield of Ohio

High Level Certificate

with Prescription Drug, Vision and Supplemental Major Medical Coverage

COSE

OF SMALLER ENTERPRISES

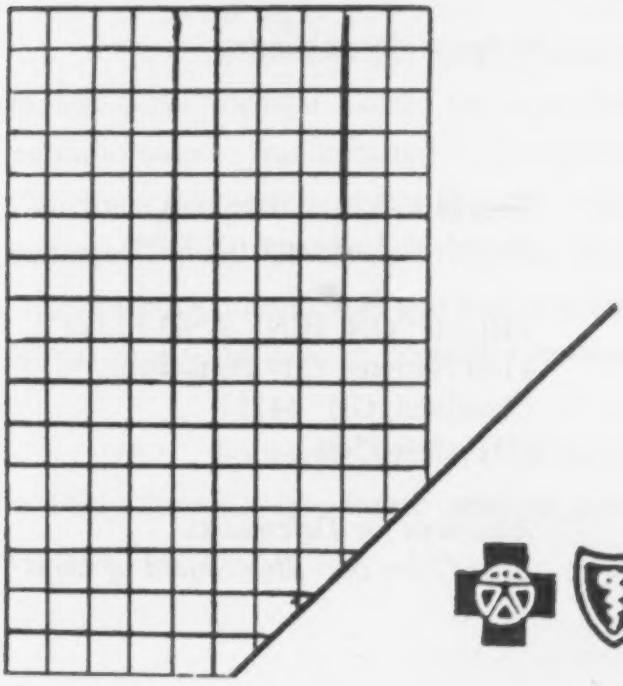


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CCY 84002
BCEY 84000
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HIGH-LEVEL CERTIFICATE

This Certificate describes the health care benefits available to you as part of a Group Contract. It is referred to as a Base Document and is subject to the terms and conditions of the Contract.

The actual Contract is between Blue Cross & Blue Shield Mutual of Northern Ohio, who will be called **we, us, our** or the **Plan**, and the employer or organization which pays or forwards the fees. We will refer to them as the **Group**. All persons who meet the following criteria are covered by the Group Contract and are referred to as **Covered Persons, you**, or **your**. They must:

- apply for coverage under the Contract,
- pay for coverage if necessary,
- satisfy the conditions specified in the eligibility section,
- be approved by the Plans.

Certain words in this Certificate are defined: they have precise meanings and will be capitalized throughout this text so that you will pay special attention to them. Refer to the definitions section of this Certificate for all capitalized words. We have tried to write this Certificate in simple terms which are easy to understand. Please read it carefully so that you will understand your coverage.

Blue Cross & Blue Shield Mutual of Northern Ohio

HOW TO USE YOUR CERTIFICATE

This Certificate gives you the details you need to understand your health care benefits. We have tried to write it in simple terms which are easy to understand. Please read this Certificate carefully.

Schedule of Benefits

A schedule of Benefits is included with this Certificate. It gives you information on the limits and maximums of your Base Documents and on any amounts you must pay; it tells what we will pay for Covered Services.

Eligibility

This section outlines how and when you become eligible for coverage under the Contract and how and when your coverage becomes effective.

Exclusions

This section lists what is not covered. We want to be sure that you do not expect benefits that aren't included in your coverage.

General Provisions

This section tells you such things as:

- How to get benefits.
- How and when your coverage stops.
- How to buy coverage if this coverage stops.

Definitions

This section defines terms that have special meanings in this Certificate. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in the definitions section or where used in the text, or it is a title.

ELIGIBILITY

Applying for Coverage

When you apply for coverage you will choose either Individual Coverage or Family Coverage. An application must be completed in either instance. In deciding whether or not to approve an application, we may request more information. Coverage will not begin until your application has been approved.

Under Individual Coverage, only the Certificate Holder is covered. Under Family Coverage, we cover the Certificate Holder and his or her Eligible Dependents.

Eligible Dependents

An Eligible Dependent is defined as:

- the Certificate Holder's spouse,
- the Certificate Holder or spouse's unmarried children, step-children, legally adopted children or any children for whom either parent is the legal guardian. To be considered Eligible Dependents, they must be allowed as federal tax exemptions.

The age limit for all eligible, unmarried children is specified in the Schedule of Benefits.

Eligibility will continue past the age limit for Eligible Dependents who are primarily dependent upon the Certificate Holder for support and who can't work to support themselves due to a physical handicap or mental retardation; this handicap must have started before the age limit was reached. This disability must be medically certified by a Physician. After a two year period following the Eligible Dependent's reaching the age limit, we may annually require further proof of the continuance of such handicap and dependency.

Effective Date

Coverage starts on the Effective Date appearing on your Identification Card. No benefits will be provided for services

Diagnostic Services

Diagnostic Services include:

- radiology, ultrasound and nuclear medicine,
- laboratory and pathology services,
- EKG, EEG and other electronic diagnostic medical procedures.

Services Performed During an Annual Physical Exam - Regardless of Medical Necessity, we will pay for the following tests once per year when performed as a part of your annual physical exam:

- one EKG,
- one chest x-ray,
- one pap smear,
- one SMA-12 urinalysis and complete blood count.

The actual physical exam performed by the Provider is not a Covered Service.

Therapy Services

Services or supplies used to promote recovery from an illness or injury include:

Radiation Therapy - The treatment of disease by x-ray, radium or radioactive isotope.

Chemotherapy - The treatment of malignant disease by chemical or biological antineoplastic agents. Oral Chemotherapy must be performed in a Hospital.

Dialysis Treatments - The treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

Treatment by Physical Means - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, bio-mechanical and neurophysiological principles and devices.

The number of visits which your coverage provides is specified in the Schedule of Benefits. We may approve additional treatments, however, if your Physician or Professional Other Provider explains in writing the reason for more treatments and we determine that they are Medically Necessary.

Respiratory and Pulmonary Therapy - This must be provided as an Inpatient or Outpatient service of a Hospital.
Inpatient Speech and Occupational Therapy

Maternity Services

Hospital medical and surgical services of normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion and nursery care of the newborn. Maternity services are payable for the Covered Persons indicated in the Schedule of Benefits.

Outpatient Mental Health Care Services

The following services for the treatment of Mental Illness:

- individual psychotherapy,
- group psychotherapy,
- family counseling - counseling with family members to assist in diagnosis and treatment,
- electroshock therapy and related anesthesia given in a Hospital or Outpatient psychiatric facility. It is not covered in a Physician or Professional Other Provider's office,
- psychological testing-limited to one battery of tests per Covered Person per Benefit Period.

EXCLUSIONS

We do not provide benefits for services, supplies or charges:

1. Which are not prescribed by or performed by or upon the direction of a Physician of Professional Other Provider.
2. Received from other than a Provider.
3. Which are Experimental/Investigative.
4. Which are not Medically Necessary, except as specified.
5. Which are for illness or injury occurring in the course of employment if whole or partial benefits or compensation are available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.
6. To the extent governmental units provide benefits.
7. For illness or injury that occurs as a result of any act of war.
8. For which you have no legal obligation to pay in the absence of this or like coverage.

9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
10. Received from a member of your immediate family.
11. Incurred before your effective Date or for Hospital services received during an inpatient stay that began before your Effective Date.
12. Incurred after your cancellation date except as specified under Benefits after Termination.
13. For the following examinations:
    - screening examinations,
    - premarital examinations,
    - x-ray examinations made without film,
    - routine or annual physical examinations,
    - physical examinations required by an employer in order to begin or continue working.
14. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits.
15. For Surgery and other services only to improve appearance but not to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes.
16. For Inpatient admissions mainly for:

- Diagnostic Services;
- Custodial Care;
- rest care;
- environmental change; or
- treatment by physical means.

17. Primarily for educational, vocational or training purposes.
18. For conditions related to an autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, except as specified.
19. For blood, blood components, blood plasma or blood derivatives.
20. For topical anesthetics or stand-by anesthesia.
21. Minor non-operative endoscopic procedures.
22. For arch supports and other foot care or foot support devices only to improve comfort or appearance such as care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, toenails and the like.
23. For treatment of obesity, including any care which is primarily dieting or exercise for weight loss, unless Surgery is Medically Necessary when weight is at least twice the ideal amount.
24. For marital counseling.
25. For the treatment of sexual problems not caused by organic disease.

26. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
27. For birth control devices.
28. For reverse sterilization.
29. For artificial insemination or in vitro fertilization.
30. For well baby care including routine exams and immunizations.
31. For the treatment of cysts or abscesses associated with the teeth, dental x-rays, dentistry or any other dental processes, except as specified.
32. For oral chemotherapy which is not administered in a Hospital.
33. For Personal hygiene and convenience gems.
34. For eye glasses, contact lenses or examinations for prescribing or fitting them (except for aphakic patients and soft lenses or sclera shells for use a corneal bandages).
35. For hearing aids or examinations for prescribing or fitting them.
36. For allergy tests, immunizations or evaluations to determine the need for the same.
37. For hypnosis and acupuncture.
38. For telephone consultations, missed appointments or completion of a claim form.
39. Which are not specified in this Certificate as Covered Services.

COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS PROVISION

All benefits provided by this health care coverage are subject to the Coordination of Benefits Provision. This provision is not to deny you benefits but to ensure that duplicate payments are not made when you are covered by this and an Other Contract.

Definitions: In addition to the definitions of the Contract and this Certificate, the following definitions apply to the Coordinations of Benefits Provision:

- **Other Contract** is defined as any arrangement providing health care benefits or services through:
  - group, franchise, or blanket insurance coverage.
  - Blue Shield Plan, Blue Cross Plan, group practice, individual practice or any other prepayment coverage.
  - coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefit organization plans.
  - coverage under any tax-supported or government program.
- **Dependent** means a person who qualifies as a dependent under an Other Contract.

Effect on Benefits

If the total benefits for Covered Services to which you would be entitled from us and under all Other Contracts exceed the Covered Services you receive in any Benefit Period, then the benefits we provide for that Benefit Period will be determined according to this provision.

When we are primary, we will pay benefits for Covered Services without regard to your coverage under any Other Contract.